

THE RIGHT MEDICINE? EXAMINING THE BREAUX-FRIST PRESCRIPTION FOR SAVING MEDICARE

HEARING BEFORE THE SPECIAL COMMITTEE ON AGING UNITED STATES SENATE ONE HUNDRED SIXTH CONGRESS SECOND SESSION

WASHINGTON, DC

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THE RIGHT MEDICINE? EXAMINING THE BREAUX-FRIST PRESCRIPTION FOR SAVING MEDICARE

TUESDAY, FEBRUARY 8, 2000

**U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
*Washington, DC.***

The committee met, pursuant to notice, at 9:32 a.m., in room SD-562, Dirksen Senate Office Building, Hon. Charles E. Grassley, (Chairman of the Committee) presiding.

Present: Senators Grassley, Jeffords, Craig, Burns, Hagel, Collins, Hutchinson, Bunning, Breaux, Feingold, Wyden, Reed, Lincoln, and Bayh.

OPENING STATEMENT OF SENATOR CHARLES E. GRASSLEY, CHAIRMAN

The CHAIRMAN. Although it has been my tradition in this committee to let any member make an opening statement, I would like to ask my colleagues if they would be willing to submit their statements for the record. I would appreciate it. If you don't want to do this because I didn't give you advance notice I would ask you to keep opening comments relatively short.

Good morning and I welcome each of you to the first Senate hearing on the legislation that is likely to become the basis for congressional debate on Medicare reform this year. That legislation is S. 1895, the Medicare Preservation and Improvement Act of 1999, sponsored by this committee's ranking member on my right Senator Breaux, and by Senator Frist, our first witness.

Today marks our first committee hearing of the year and the first congressional hearing on the only pending bipartisan bill to reform Medicare. I chose Medicare as our first hearing topic to demonstrate this committee's priorities not only for this year, but for the past 3 years.

Health care coverage is critically important to older Americans. Medicare covers 39 million Americans today. It will cover many more Americans tomorrow, and if we make the right choices to save it, we will be able to accomplish that goal.

The reasons fueling Medicare reform are very well-known. One reason is financial. Medicare will go bankrupt within about 15 years if we don't take action, and take action very quickly. At least by taking it quickly, we don't hurt anybody. If we wait too long, we hurt everybody because it is more painful to wait and make changes later on.

Another reason, of course, is the need to modernize the program. Medicare is old-fashioned in lots of ways. One high-profile example is that it doesn't cover prescription drugs, which are increasingly vital to our health care system, replacing what used to be long hospital stays for illness or operations.

The Breaux-Frist plan responds to both of the engines driving reform. I chose to begin with this legislation not because I assume it is perfect or a complete plan, but because it provides us with a good framework on a very complex discussion.

The questions we have to answer include whether this plan would provide health coverage for beneficiaries that is as reliable as current Medicare coverage and exposes beneficiaries to no heavier financial burden, whether the proposal would provide equity for rural areas—I am pleased that we have as a witness from my State of Iowa with us, Steve Goesser, who will discuss ways that the Breaux-Frist plan might affect rural areas—and whether we can provide a prescription drug benefit that beneficiaries can afford without making Medicare's financing problems even worse than they are now, and, last, whether the Breaux-Frist bill's Medicare Board can oversee a reformed Medicare system and provide the many protections for beneficiaries that we now expect from the Health Care Financing Administration.

Skeptics predict that Congress won't take on these tough questions in an election year. Beginning today, I hope we prove them wrong. I hope our momentum continues. I believe strongly that we shouldn't squander the opportunity to make progress and build consensus on a plan to save Medicare.

Everything is in place for us to do our work. We have a plan on the table, we have a bipartisan agreement on the need for reform, and we have millions of older Americans who expect, and most importantly deserve, results from this Congress. So I want to thank Senators Breaux and Frist for their work on this issue, and also offer thanks to our witnesses for being with us today.

[The prepared statement of Senator Grassley follows:]

PREPARED STATEMENT OF SENATOR CHARLES GRASSLEY

Good morning.

I would like to welcome everyone to the first Senate hearing on the legislation that is likely to become the basis for the congressional debate on Medicare reform this year. That legislation is S. 1895, *The Medicare Preservation and Improvement Act of 1999*, sponsored by this Committee's ranking member, Senator Breaux, and by Senator Frist.

Today marks our first Committee hearing of the year, and the first congressional hearing on the only pending bipartisan bill to save Medicare.

I chose Medicare as our first hearing topic to demonstrate this Committee's priorities. Health care coverage is critically important to older Americans. Medicare covers 39 million Americans today. It will cover many more Americans tomorrow, if we make the right choices to save it.

The reasons fueling Medicare reform are well-known. One reason is financial. Medicare will go bankrupt within 15 years if we don't take action. The longer we wait, the more painful it will be to make the changes in the program that are needed.

Another reason is the need to modernize. Medicare is old-fashioned in a lot of ways. One high-profile example is that it doesn't cover prescription drugs, which are increasingly vital to our health care system.

The Breaux-Frist plan responds to both engines driving reform. I chose to begin with this legislation not because I assume it is the perfect and complete plan, but because it provides us with a good framework for a complex discussion. The questions we have to answer include:

- whether this plan would provide health coverage for beneficiaries that is as reliable as is current Medicare coverage and exposes beneficiaries to no heavier financial burden;
- whether the proposal would provide equity for rural areas. I am pleased that we have a witness from Iowa with us today, Steve Goeser, who will discuss the way the Breaux/Frist plan might affect rural areas;
- whether we can provide a prescription drug benefit that beneficiaries can afford without making Medicare's financing problems even worse than they are now;
- and whether the Breaux-Frist bill's Medicare Board can oversee a reformed Medicare system and provide the many protections for beneficiaries that we now expect from the Health Care Financing Administration.

Skeptics predict that Congress won't take on these tough questions in an election year. Beginning today, we're proving them wrong. I hope our momentum continues. I believe strongly that we shouldn't squander the opportunity to make progress and build consensus on a plan to save Medicare. Everything's in place for us to get to work. We have a plan on the table. We have bipartisan agreement on the need for reform. We have millions of older Americans who expect—and deserve—results.

I would like to thank Senators Breaux and Frist for their work on this issue, and also offer thanks to our witnesses for being with us today.

Senator Breaux.

STATEMENT OF SENATOR JOHN BREAUX

Senator BREAUX. Well, thank you very much, Mr. Chairman, and thank you for calling this very, very important hearing to give us a chance to address the entire question of Medicare reform and how we should go about doing it.

The conventional wisdom generally says that you cannot deal with Medicare reform the year before an election and, for heaven's sake, you certainly can't deal with it in a year of an election. If you follow that philosophy, that would mean that we could never, ever deal with Medicare because every year is either an election year or the year before an election. So thank you for having the courage to have an airing of all the ideas and suggestions and comments about what we need to do in an effort to try and pass real reform in this Congress.

Also, I think that there is a real strong desire now to add more benefits to the Medicare program, principally in terms of a prescription drug plan. I happen to support prescriptions drugs for Medicare recipients very strongly, but I think that this presents us an opportunity to combine the two, to combine the prescription drug added program, at the same time trying to fix underlying problems that are associated with the Medicare program.

The Washington Post noted in an editorial just a couple of days ago that, quote, "A drug benefit is needed but, in our view, should await and be used to sweeten a more complete restructuring," unquote. It further pointed out that adding prescription drugs to Medicare without reforming Medicare is like adding lead weights to a sinking ship; it is not going to help the ship float any better.

I think that it may be possible that we can do an incremental reform of the Medicare program this year along with an incremental addressing of the prescription drug plan. That would certainly be better than we have right now. I am certainly willing to try and accomplish as much as we can in both of these areas. I would like to do everything that is needed with prescription drugs and everything that is needed to reform the program. But if that is not possible, it should not deter us from trying to do what we can in both areas.

As I think you said, Mr. Chairman, the Breaux-Frist bill, S. 1895, is really a marker. It is not intended to be the final word from my colleague and I on how this ought to be brought about. It is the work product of a lot of people who have worked very long and hard on this effort to try and help put this together.

But I would comment that I think that last year, particularly members of the Finance Committee, and all members of the Senate, really went through an experience that no Member of Congress should have to go through again in terms of trying to partially allow Medicare to last one more year.

We all remember in the balanced budget add-back bill when we sat in the Finance Committee, and members on the floor were asked to do the same thing, to decide whether the RUGs should be increased for SNFs, whether the IME funding should be reduced 7 percent instead of 7.5 percent, how to fix the APC system for hospital outpatient, and how to adjust a \$1,500 therapy cap imposed by BBA 1997.

That is certainly not the way that Congress needs to run a program for 40 million Americans. That is micromanagement at its worst. We are called upon to make a decision that we do not know what the correct decision is, and it continues ad infinitum.

Just this year, the President's budget that was released just yesterday with regard to Medicare includes provider cuts of eight-tenths of 1 percent in the hospital update. I mean, our hospitals are coming to every one of our offices saying that they were hurt very badly and need more money. Yet, we are looking at more cuts.

We are looking at a proposed reduction in the prospective payment system, capital payments, by 2.1 percent, reducing lab payments by the Consumer Price Index minus 1 percent, and the list just goes on and on. This is not the way to run a health care program for 40 million Americans. We cannot continue to handle it in this fashion, in addition to the fact that Medicare—I just have to say it and I think many people understand it—is not nearly as good as it should be or as good as it can be.

It covers 53 percent of the costs of an average senior's health care. That means 47 percent has to come from someplace else. No other health plan carries that burden on the beneficiary of the program. And in addition to having to pay about \$2,000, on average, out of pocket every year for a Medicare beneficiary, in addition to what it doesn't cover, the program is going broke and is expected to be insolvent by the year 2014.

So, anyway, I think, as David Walker points out in his testimony, Medicare Part A has been in the red since 1992. I mean, the projected deficit this year is \$7 billion, just this year. So we have a program that is not nearly as good as it should be that is going broke and is already spending \$7 billion more every year than we are taking in to cover it.

So I think we have to face the problem that we have and we have to try and look at reforming it, adding prescription drugs, but bringing about real reform. And I am very pleased that Senator Frist will be presenting his testimony this morning outlining a comprehensive plan to do just that. It is not perfect. It is certainly subject to amendment and criticism and suggestions. But, together, in a bipartisan fashion I think that we ought to grasp this oppor-

tunity and this very unique time in order to bring about true reform.

Thank you, Mr. Chairman.

The CHAIRMAN. I would like to go to Senator Frist now because he is under a time constraint. I will accommodate my colleagues at the end of Senator Frist's statement, if you want to make an opening statement, a very short one please, at that particular time.

I want to introduce our distinguished colleague Senator Bill Frist, the Senate's only elected member who is also a medical doctor. He also served on the National Bipartisan Commission on the Future of Medicare. He and Senator Breaux introduced the first and only comprehensive bipartisan Medicare reform bill this Congress.

So, Bill, I appreciate very much your coming today to open this very important Medicare reform hearing.

Senator Frist.

STATEMENT OF SENATOR BILL FRIST, A U.S. SENATOR FROM THE STATE OF TN

Senator FRIST. Thank you, Mr. Chairman, and to the ranking member and other colleagues. This is the first presentation before Congress of S. 1895 that Senator Breaux and I introduced, along with Senators Kerrey and Hagel, last November. So I am honored to be able to open the discussion. The witnesses to follow will in much greater depth look at the particular piece of legislation, but again very important, I believe, for setting the foundation for issues that we know are all critical to us, to our families, to our parents, to our grandparents, and to our children.

Much of the work and almost all of the principles that have been incorporated in S. 1895 are derived from a more than 1-year-long discussion of the National Bipartisan Commission on the Future of Medicare, a 17-person commission appointed by the President of the United States and leadership in Congress to address the fundamental issues of financial viability and how we can provide real security in terms of health care benefits for individuals with disabilities and our senior citizens.

It has already been mentioned today and it will come up again and again why we need to reform Medicare, but it really comes down to two fundamental issues. One is the need to protect and strengthen the long-term viability from a financial standpoint. We in Washington do a pretty good job talking about that, but I think equally important is the overall health care security that we provide our seniors and individuals with disabilities, which is really what Medicare is all about. So we look at the program financial viability, but also the type of care, quality of care, that our seniors and individuals with disabilities receive.

Already this morning, the issues have been mentioned. Insolvency in the year 2015. Right now, Medicare spending, if left unchecked, will have an increasing share of the Federal budget, reaching 25 percent of the overall Federal budget by 2030.

General revenues. As the ranking member mentioned, 37 percent of total Medicare expenditures are paid by general Treasury revenues, just a draw on the Treasury itself, 37 percent of all Medicare expenditures. What has not been mentioned is we are basically

dealing with a cash drawer, seniors and individuals with disabilities receiving benefits taking out of the cash drawer. Coming into the cash drawer are what workers are paying in.

Two issues. First, we have a doubling of the number of seniors taking out over the next 30 years, and that is critical because this is a demographic wall that is there. We can't move it, we can't slip around it. We can't go too slow because that brick wall is there. On the flip side of the equation is what is being paid in. As we all know, there is a decreasing number of workers paying in.

In 1960, there were 4.5 workers for every senior taking out, and today it is 3.9 workers for every senior or individual with disability. In 2030, it goes down to 2.8. Thus, these people are having to work twice as hard as they were 30 years ago for each senior taking out of the system.

Now, it has also been mentioned that the system is inadequate and it is outdated. The figures has been mentioned—and most people don't realize this—that of Medicare expenditures, on average, per beneficiary, only 53 percent is paid for by Medicare. Now, that is inadequate. That is not true in the private sector today. Again, let me repeat, on average, a beneficiary, a senior citizen, of their health care expenditures, only 53 percent is paid for by Medicare. It is inadequate by today's standards. No. 2, it is outdated. The benefit package is not up to what people in the private sector receive. Most seniors don't receive that.

Micromanagement. I want to mention micromanagement because I just came off these hearings on gene therapy the other day, which is a perfect example of science and the rate at which science is moving. Medicare is too inflexible, it is too rigid to incorporate the good innovations that we know about.

A couple of examples just to drive it home. In 1994, the Food and Drug Administration approved a technology which improves healing of bones, of bone fractures. Today, 850 private insurers across the country approve this bone fracture healing approach. Medicare does not approve it today. That was from 1994. Slow to capture innovations.

Second, inadequate preventive screening. We talk about prescription drugs and that is really going to be the focus, but right now preventive care is not a part of Medicare today. It is totally inadequate. I am a heart surgeon, as all of you know. I spent my life doing heart surgery before coming here. Coronary artery disease; we all know the relationship between cholesterol, the importance of keeping certain types of cholesterol down. Medicare does not reimburse for preventive testing, like cholesterol. It just doesn't make sense today.

A third example that will strike home to many of you is prostate cancer screening. We know that prostate screening tests came on the market in the early 1990's. It took an active Congress for us to get that one test reimbursed. Talk about micromanagement. Years after the test was being used. In the 1998 Balanced Budget Act bill, we had to put in there PSAs, prostate screening tests. That sort of micromanagement is absurd with today's technology.

Now, what does our bill do? Basically, when I explain it to people, and you will go into detail, it is basically based on the model, the foundation of the Federal Employees Health Benefit Plan. That

is the way the President of the United States receives health care. It is the way I and my colleagues receive our health care. It is a model that we have 40 years more experience than we have with Medicare. We have 40 years of experience with this plan.

It hasn't always been pretty. It has been good and it has been bad, but we have learned from it and improved upon it, where today it has more information for consumers, more information for us as we choose our plans, more choice, and more security. There are about 9 million Federal employees today who do receive their care through this FEHBP model.

It does several things. It guarantees all—and this is what our bill does—it guarantees all current Medicare benefits, which is very important because when we talk change, it becomes very frightening to people. You can tell them right up front it guarantees all current Medicare benefits, so that beneficiaries at a minimum will receive everything which they are entitled to today.

Second, it offers universal prescription coverage, and this where a lot of the attention is going to be. We need to focus on that. What it makes possible is prescription drug access for every senior, with every senior having some subsidy in order to get that prescription drug coverage if they choose to do so. You will talk more about that in the following panels, but it is very important to talk about that prescription drug coverage.

The point is we incorporate that benefit into an integrated health care delivery process instead of looking at it as another benefit that you add, whether it is on a sinking ship or whether it is on a Medicare system that is inadequate today. And it is important conceptually that that Medicare coverage be brought into the arena of integrated health care.

We have a sliding scale, just as an aside. For up to 135 percent of poverty, the premium for that drug coverage is paid for by Government. Between 135 and 150 percent of poverty, it is a sliding scale, where you are subsidized from 25 to 50 percent of that premium. Above 150 percent of poverty, 25 percent of the premium is paid by for Government for everybody. Again, the details you can come back to in a little bit.

Third, we protect beneficiaries from out-of-pocket expenditures. Most people who look at Medicare don't realize there is no cap. If you have a heart transplant or if you have cancer, there is no cap in Medicare today for out-of-pocket expenditures. Those who enroll in our enhanced or high-option plan, there is an—and you get to choose whether or not you go in that plan—there is a cap as to how much you will be responsible for.

Fourth, we provide very specific protections for low-income beneficiaries. As I said, those people below 135 percent will have their premiums paid for, not just for prescription drugs but for their entire plan.

Fifth, we offer very specific rural health care protections. Again, after much discussion on the Medicare Commission, we recognized that in terms of competition and choice you have to pay very special attention to what happens in rural communities.

Outreach and education is very important. Think about FEHBP, the book that you get. You get to choose. You see how consumers and beneficiaries have rated those plans. You see what the range

of services are. Compare it to what someone gets in Medicare today, really essentially nothing. We have in this particular bill strong patient education and outreach.

So the key words are, based on what I have said, capture the innovations of the marketplace today, where science is moving fast. We are learning a lot about health care delivery systems. Instead of having a rigid system that is slow to change—and think of the examples I gave you about whether it is prostate screening or whether it is cholesterol or preventive medicine.

What happened last year is we came in with the BBA and we cut Medicare drastically to achieve our goals, long-term financial viability. It became pretty apparent that we were going to destroy health care in this country by killing our academic health care centers, by destroying rural health. So we came in again with some micromanagement at the end of last session and said, no, that was the wrong thing to do, let's put some more money back in it.

We cannot any longer, with the technology, the new innovations, the changes in health care delivery systems, micromanage as United States Senators what today is Medicare, governed by over 100,000 pages of regulations. That is three times what the IRS has, Medicare today. That is what we are doing. That is what we are trying to do, and trying to run it out of Washington, D.C. Flexibility, capturing those innovations. It is a voluntary option. We are not forcing anybody into managed care. You can keep what you have or you can go into this plan which has flexibility in a more integrated way.

In closing, we have a real opportunity. Prescription drugs is where the focus is going to be among all of us. Outpatient prescription drugs which are not covered by Medicare must be a part of Medicare. How we do it is our responsibility. How we respond to that appropriate demand by the American people today for that prescription drug coverage is key.

I believe if we just add a benefit in response to that, potentially a very expensive benefit, onto a system that is administratively inflexible, that is administratively out of date, that is administratively not up to the times, not modernized, at the same time a system which is going bankrupt—we all know that it is because you have that demographic wall there that is not going to move. We have a great opportunity when you put that together, I believe, to incorporate prescription drug coverage into an integrated health service delivery system that will improve care, improve security, and improve choice for our seniors.

I think that sort of sets the stage for where we are, why we have done it, what we have on the table. It is a first step. It is based on bringing the leading experts in the United States of America, and that is not people from here in Washington, D.C.; it is from all over America, to testify before a commission, to bring the people who have thought more about this than anybody, not just politicians.

We have done our very best in a bipartisan way to put it on paper, to be that first step, to be that foundation for discussion, to be that framework where we can intelligently improve, yes, prescription drugs, but also choice and security for our seniors.

Thank you, Mr. Chairman. I appreciate it.

The CHAIRMAN. If there are questions, I will call on members in order of arrival, Senators Breaux, Wyden, Bunning, Craig, and Hutchinson, to start with.

Senator Breaux.

Senator BREAU. I don't want to belabor the point. I thank my colleague for his presentation. I think it was right on point. I think that a point that you mentioned cannot be overemphasized. Under the bill that we have introduced, we are giving seniors more choice. If someone likes to go into the new system, they have the right to do that. But if they prefer staying in the current fee-for-service Medicare plan, they can stay there.

I would hope that they would see that the new system can offer them more opportunities and more security, but if they feel comfortable, as your testimony pointed out, with the current fee-for-service system, they will have the opportunity to stay right where they are. And you made that point very well.

The CHAIRMAN. Senator Wyden.

Senator WYDEN. Mr. Chairman, thank you. Could I make a brief opening statement and then ask a question or two of Senator Frist?

The CHAIRMAN. Why don't you ask the questions now and then make a brief opening statement afterwards so he can go?

Senator WYDEN. Bill, you obviously, with John, have put a lot of work into this. I think you know that Senator Snowe and I have also teamed up for more than a year on a bipartisan approach, and we got 54 votes on the floor of the Senate to fund that proposal.

You clearly want to have competitive principles. We do, as well. You also clearly would rather do comprehensive Medicare reform all at once, and we share the view that it makes sense to try to do it all at once. However, hardly anybody thinks that you can get comprehensive Medicare reform through the Congress in the 60-plus days that we have got left in this year.

What do you think about the idea of jump-starting comprehensive Medicare reform by, in effect, bringing together the approach you have taken, the approach that Senator Snowe and I have taken, and some of the ideas of the administration, because I happen to think that there is a coalition that is out there for doing just that? For example, the administration's proposal uses these pharmaceutical benefit managers. Your bill and my bill use these private entities through the Federal employee health system. I think those two can be reconciled.

If you and John can't get all the way down the road in 60 days for comprehensive Medicare reform, are you comfortable with the idea of trying to jump-start Medicare reform by acting in a bipartisan way, using marketplace principles, and bringing together the administration, another bipartisan bill, and yours so that at least we meet this enormous need for prescription drug coverage that is out there now and get it done this year?

Senator FRIST. I opened my comments by basically saying that a real goal is not just adding a benefit because of the potential harm that that could do. Ultimately, and clearly, the dialog has to go on. That is why this hearing is so important. That is why in my opening words I said what we really need to focus on is security for that individual patient who comes into my office, Bill Frist, heart surgeon, who has angina and needs care.

The danger is taking, not yours, but a \$200 billion—as the President put on the table, a \$200 billion benefit, a good benefit, a benefit we have got to have incorporated in the system, and put it on a system that is failing, for the reasons I outlined. And it is easy to piecemeal this, but if a system is failing and you put a \$200 billion benefit on, in the short term it is popular and it would pass with, not 54, but 95. Why? Because it has to be incorporated.

In terms of our responsibilities as trustees to that senior—when I close my eyes, I see that person coming into the office, and recognizing you are hurting them because you are accelerating the demise of a system which we all know, because of that demographic wall, is there. Therefore, my call is that, yes, we need to figure out how to integrate this, and that is why we will repeatedly say that this is the foundation, this is the first step.

My big fear is that not necessarily your bill, but somebody, because it is so popular, will come in and put a \$200 billion weight on something which is going to go down in a good way. And we have to give that assurance to the American people and to our body. And I think that is what Senator Breaux is saying, is step by step.

Now, people will come out and say, well, let's just modernize HCFA a little bit and then let's put this benefit on there. That is totally unsatisfactory. That doesn't address the inadequacy, the inflexibility, the demographic shift, the lack of incorporation of innovation, all the things that we get, that our seniors deserve, and that we have got to have the guts to face.

Can it be done in 8 months? It could be done if the President came forward and said it could be done because we are bipartisan, I think, as a group, not this particular bill, but I think we all want to do something. It would take real Presidential leadership, I believe, to do that.

So what is the answer? Yes, we should figure out what to do, what those steps should be. Again, I am going to argue for that security for the senior and not just tinkering around the edges. We have done that for too long and it hasn't worked.

Senator WYDEN. Mr. Chairman, I will wrap this up very briefly. I want it understood, because you all have put in a lot of time, I would rather do it in a comprehensive kind of way. I do think, however, approaches like ours, and bringing the administration as well, is consistent with long-term Medicare modernization.

For example, in our approach what we do is use those dollars that 54 Senators voted for to pick up the prescription drug coverage portion of a senior's private health insurance premium. That is consistent with what you and John want to do and FEHBP. Our bill is modeled after FEHBP. I think we can bring the administration to the table.

My first choice is to try to do it all in a comprehensive way, but I hope that we can also say if you can't do that in 60 days, let's remember there are some other ways to get where we need to go for 21st century Medicare.

Thank you.

The CHAIRMAN. Senator Bunning.

Senator BUNNING. Thank you very much, Mr. Chairman.

Let me try to get a handle on this. Seven billion dollars in 2000? That is the deficit in Medicare Part A?

Senator BREAU. 1999.

Senator BUNNING. In 1999. What is it projected for 2000?

Senator FRIST. We don't know. It will fluctuate from year to year, and I don't know what the projections are. The people behind me probably know what it will be.

Senator BREAU. GAO will know.

Senator BUNNING. GAO will know. It is more than \$7 billion, or is it less?

Senator FRIST. It will fluctuate. The last 3 years, it fluctuated. It shows the difficulty of the numbers. When we come in and do these drastic, drastic cuts and we all of a sudden 6 months later put it back up, it is going to be hard to really predict.

Senator BUNNING. Let me get to the prescription drug benefit. Your pay-for in the prescription drug benefit is what?

Senator FRIST. In terms of how it is paid for?

Senator BUNNING. Yes.

Senator FRIST. Well, we are actually putting a subsidy on the premium. The details of it, again, you can talk about later, but we will put an actuarial value starting off with about \$800 in terms of prescription drug coverage that will be paid for by a combination which I explained in the sliding scale. But it will actually be part of the overall program integrated into it. The sliding scale—under 135 percent, you don't pay for it.

Senator BUNNING. Do you think that will cover the prescription drug benefit as you have proposed it?

Senator FRIST. Yes, yes.

Senator BUNNING. It seems to me if we don't do what you have proposed from the beginning, make sure that we salvage Medicare and change it, if we add the additional cost of a prescription drug benefit, we are going to sink it faster than the proposal of 2015 or 2014.

Senator FRIST. Well, what we know is that in this competitive premium support model there are cost savings; at least the Medicare Commission concluded that there in our discussions. And clearly those savings—by having a more efficient, more integrated health care delivery system, those savings clearly will allow you to extend the benefit for prescription drugs.

Senator BUNNING. Bill, did you all in the Medicare Commission also discuss the fact that there should be a portion of the population of seniors that have an income of "x" amount of dollars—I am going to pull a \$75,000 figure out of the air—and say, by the way, they ought to pay for all their prescription drugs?

Senator FRIST. Yes, and the Commission itself didn't actually conclude on that. The prescription drug part of what Senator Breau and I have put on paper and have proposed is not what the Medicare Commission itself made as a final recommendation. We have some subsidy for everybody because of the overall cost of prescription drugs. Even if you make more than 150 percent, you get some subsidy by the Government, around 25 percent of the premium.

Senator BREAU. But if the Senator will yield, the subsidy would be counted as income for upper-income individuals in our plan. So, in a sense, it is means-tested.

Senator BUNNING. Well, it is means-tested, only you are going to subsidize it and then charge them income for it?

Senator BREAU. For upper-income seniors, yes.

Senator BUNNING. Wouldn't it be better not to charge them and make them pay for the whole prescription?

Senator BREAU. Unless you are from Palm Beach, yes.

Senator BUNNING. Unless I am from Palm Beach or Southgate, Kentucky, for that matter.

Senator BREAU. I agree.

Senator BUNNING. Thank you very much, Bill.

The CHAIRMAN. Senator Craig.

STATEMENT OF SENATOR LARRY CRAIG

Senator CRAIG. Bill, let me thank both you and Senator Breau for the obvious leadership you have decided to take on this issue. I am extremely concerned that we separate out prescription drugs apart from true Medicare reform, so I think you both have approached that in the right manner.

When American seniors are polled on that issue, while prescription drugs poll very highly, they are very frightened that we will weaken and damage Medicare. And if there is an option there, they opt for what they have versus what they think they might get. We are getting a certain spin out there right now in an election year that prescription drugs is the mantra we will all chase. If we do that and fail to reform the system in totality, we will have made a great error, and so I think we can keep this thing together and march toward full reform.

I would also suggest that whether it is a sliding scale or a means test, let's get real about who can and who cannot afford health care. And while I would look for full payment for seniors who cannot afford prescription drugs, I will tell you that I have people in Idaho, as all of my colleagues have, who are very wealthy who are frustrated that they can't pay their medical bills sometimes. They are forced to allow Medicare to pay it and they really feel they are draining the system.

But we have never wanted to do that. We have always treaded lightly, and I see you have found a way to spin it backwards and, of course, Senator Bunning reacted to that. Why don't we get honest? We could do a tax credit, we could do other things. But seniors who make those levels of income can afford to pay for that kind of health care.

Let me ask one last thing.

Senator FRIST. Let me just add, as you know, it is, in essence, against the law for even the very wealthy to pay for their Medicare benefit.

Senator CRAIG. It is.

Senator FRIST. That is correct.

Senator CRAIG. I have got a multi-billionaire in Idaho who is very frustrated that he couldn't pay for his hip surgeries, but he wasn't allowed.

Now, the last issue that frustrates me a bit. There is a reality check out there of who is really paying for the true cost of prescription drugs and who else in the world is not. And if we have decided to use tax dollars to subsidize that, I think we are erring. I think we are going to have to look for some reform in the pharmaceutical industry so that there is a baseline that the world pays for the kind of research that is necessary to bring about these marvelous new wonder drugs that we have.

I am not saying the money shouldn't flow for research and technology. I am suggesting that an American seniors program shouldn't be almost the exclusive payer of that research while the rest of the world is the beneficiary. And I think somehow we have got to deal with that as we deal with the whole issue of prescription drugs.

Senator FRIST. I know my colleagues know, but health care costs in this country will go to double digits this year. Most people do not know that today. This will include the private sector. You can say it will not include the public sector because of the artificial constraints we have put on it, but overall health care costs in this country will dramatically increase over the next 12 months. Much of that is driven by prescription drugs which we don't have a handle on.

The whole point of saying prescription drugs can be isolated out as a benefit is they have to be made a part of an integrated health care delivery system where you can see, with coordination, what those costs are, what is appropriate. That is the whole idea of making it an integrated part of the system.

Senator CRAIG. Thank you.

The CHAIRMAN. Senator Burns.

Senator BURNS. Thank you, and again I want to congratulate you and Senator Breaux. Senator Breaux and I work on a lot of different issues together, this being one.

I want to ask both of you in your findings—Senator Breaux can remember when I came to the Senate we had a catastrophic health care plan. I wasn't here when it was passed, but I was sure here when it was repealed, and I mean to tell you it raised a little dust around this town, this 17 square miles of logic-free environment here.

I am wondering if you have talked to enough groups. Now, it sounds like in your prescription drug approach that we are looking at something similar as far as people who pay premiums or whatever, or the amount of subsidy. Has the mind set changed to the point where you think that would be acceptable, that type of an approach?

Senator BREAUX. If I could just jump in, I think that Senator Wyden's approach and so many of the other approaches on prescription drugs all have a commonality that is very, very close. I mean, you can say you are going to subsidize all of the poor people on Medicare, lower-income people up to 135 percent of poverty, and give them the prescription drugs free of charge and then have some kind of a graduated declining subsidy up to about 150 percent, and then a subsidy for everybody else, whether it is 25 percent, or some have suggested 50 percent, and do it through competition in the

private sector. So there is a lot of commonality in everybody's approach on what to do with prescription drugs.

Senator WYDEN. Can I just add one other point to my colleague? One of the lessons that has been learned—and you see it in what John and Bill are trying to do and what Olympia and I are trying to do and the President's bill—is that this must be a voluntary approach.

What was learned in the catastrophic bill is that so many seniors said I am already getting this particular benefit and I do not want this one-size-fits-all Washington, D.C., approach jammed down my throat. So I think you will see all of the approaches are trying to learn the lesson.

Senator BURNS. Well, talking to the folks in Montana, that is the feedback I am getting that they have plans, even their prescription drug plans. They don't want to lose those plans.

Senator FRIST. That is correct.

Senator BURNS. And I am saying has the mind set changed from 1989, you know, whenever we went through that process as we work on this. And, yes, I would say I support the idea that Senator Wyden made that I think this is going to have to be a collaborative affair because we are going to need strong White House leadership for a total, comprehensive reform of the system.

So I have no specific questions other than has the mind set changed to where we can actually get it done.

The CHAIRMAN. Senator Frist.

Senator FRIST. Well, I think also for the prescription drug coverage, when we say in terms of covering for the people above 150 percent, what we are doing is subsidizing the premium for a plan. It is not like all your drug coverage—you are coming in and we are paying 25 percent unlimited. The idea is to subsidize a portion of the plan.

You do this by getting these actuarial values of the plans. You take that and you have to pay a premium for that plan. We are subsidizing the premium for the plan. So you still have some element of cost controls, what the plan actually does in terms of making sure appropriate use is there, instead of just having a free-for-all and saying your drugs are free or we will pay 50 percent of all your drugs.

Even under the President's proposal yesterday, for next year if somebody has \$250 a month in costs, out of pocket they are still paying 80 percent and the Government is only paying 20 percent. That is not that great of a deal, so we have to really look very carefully at the plans.

Senator BURNS. Senator Frist, give me your impression. You say health care is going to go up. Now, we have been told we have had no inflationary pressure for the last 3 or 4 years, and I have taken issue with that because I tell you what, there ain't nothing I don't buy that doesn't cost more. And they tell me there ain't no inflation. Now, they ain't doing their own shopping.

What is driving this cost?

Senator FRIST. Pharmaceuticals, No. 1, and that is why we have to be very careful what we do. It is out of sight. The demand is there, for all sorts of reasons we can address. But, No. 1, the pharmaceutical charges are skyrocketing, with no control, and that is

why this discussion is critical, how we handle it. If we are going to go with prescription drugs, which we must do, it has got to be in some sort of environment where it is not to allow this skyrocketing, which will drive everything bankrupt.

No. 2, technology. The rapid rate with which technology is moving, it is very expensive. No. 3, the rising demand. The demand is there. We want the very best for our spouse who is dying of cancer, or for our parents. And in America when there is a demand like that, it will be provided. That is why a system-wide approach, coordination, is important.

Senator BURNS. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Collins.

Senator COLLINS. Thank very much, Mr. Chairman. I have a very eloquent opening statement, but since there are so many people here, I will ask that it be put into the record.

The CHAIRMAN. We accept it joyfully.

[The prepared statement of Senator Collins follows:]

PREPARED STATEMENT OF SENATOR SUSAN COLLINS

Mr. Chairman, thank you for convening this morning's hearing to examine ways to address Medicare's underlying structural problems and to discuss how we can best update the program so that it meets the health care needs of today's seniors, and in particular their need for affordable prescription drugs.

Medicare has been a fine program for the 20th Century. For over thirty years, it has provided millions of older and disabled Americans with affordable and dependable health insurance that has given them access to the highest quality care. Medicare is so much a part of our lives that we tend to forget that, prior to the establishment of Medicare in 1965, fewer than 50 percent of our nation's elderly had health insurance. Today, nearly 40 million older and disabled Americans rely on this critically important program for their health care. Medicare has not only helped our parents and grandparents to live longer and healthier lives, but it has also helped to reduce the number of older Americans living in poverty.

The experts tell us that Medicare is fiscally unsustainable in its current form. As we will hear from our witnesses this morning, the Medicare hospital insurance trust fund has been running in the red since 1992. Without major structural improvements, it will be totally insolvent and unable to pay benefits by 2015—just as the crest of the tidal wave of retiring baby boomers breaks and sweeps them into the program.

Moreover, while the Medicare program may have been just fine in the 1960s, when its benefit package was created, it is completely out of date today. It is time for us to update Medicare and bring it into the 21st century to ensure that all Americans have access to the most modern medical care. Nowhere is this more important than in the area of prescription drugs. As Congress focuses on ways to modernize and restructure Medicare, it is imperative that we include a prescription drug benefit to make drugs more affordable for the group that needs and uses them the most: our nation's seniors.

In stark contrast to the vast majority of insurance policies for the under-65 population, which provide generous drug benefits, Medicare currently does not pay for outpatient prescription drugs. While many Medicare beneficiaries do get some assistance with drug costs through retirement plans, through Medicaid, or through supplemental "Medigap" policies, an estimated one-third of our nation's 34 million elderly Medicare beneficiaries must pay the entire cost of their medications themselves.

Moreover, even seniors who get some help with these costs face significant limits. The best Medigap policy that older Americans can buy—which in itself is out of the financial reach of most Medicare beneficiaries on limited incomes—pays for only half the costs of prescriptions, imposes a \$250 deductible, and is capped at a maximum annual benefit of \$3,000.

Prescription drugs are as important to a Medicare beneficiaries' health today as a stay in a hospital was in 1965, when the program was created. Medicare clearly should be restructured to reflect those changes. Drugs that are routinely prescribed today to regulate blood pressure, lower cholesterol, or ward off osteoporosis had not even been invented when Medicare began. Prescription drugs are playing an in-

creasingly important role in medical treatment. They can literally be a life-line for patients whose drug regimen protects them from becoming sicker and reduces the need to treat serious illness through hospitalization and surgery.

It is therefore critical that we find a way to make certain that they are within the financial reach of all Medicare beneficiaries. It is no longer a question of whether we can afford to provide prescription drug coverage through Medicare, but rather, can we afford not to.

This will, however, present an extremely difficult challenge for the Congress, particularly at a time when we so clearly need to restrain, not increase, the growth in Medicare spending to restore its solvency. I therefore want to commend our colleagues, Senator John Breaux and Dr. Bill Frist, for their extraordinary efforts in developing the first, bipartisan comprehensive Medicare reform plan.

Again, thank you Mr. Chairman, and I look forward to the upcoming testimony.

Senator COLLINS. I do want to commend both Senator Frist and Senator Breaux for their far-sighted leadership in proposing comprehensive and responsible Medicare reform. There is no question that if we were designing the Medicare program from scratch today, we would obviously include some sort of prescription drug benefit. It is just as important as the coverage of hospitalization was when the program was first designed back in the 1960's.

I would say that I am more optimistic than my friend from Oregon about the possibilities of comprehensive reform this year because so much work has already been done by the Medicare Commission in this area. But it seems to me that it depends entirely on the willingness of the President to negotiate and come to the table, and I hope that will happen. I hope we can make real progress this year and deliver an improved system that will help keep our seniors healthy in the years to come.

So, again, I want to thank you for your leadership, and thank you, Mr. Chairman, for holding this hearing.

The CHAIRMAN. Senator Hagel.

Senator HAGEL. Mr. Chairman, thank you. Dr. Frist, thank you. I was one of the original cosponsors of the Breaux-Frist bill, and I did it so early on because, first, it is my opinion that the comprehensiveness, the completeness, the integration of all the dynamics of health care must come together in one reform.

You mentioned 100,000 pages of Medicare regulations. If we want to see more of those, like the tens of thousands of regulations we see in the IRS Code, then we will follow the same pattern we have followed around here for years. And that is to just keep tagging on, tagging on, and tagging on more regulations. First, it must be an integrated health care delivery system that takes into account all the pieces.

Second the other dynamic that we can't lose sight of here—and you have just stated it very correctly—is that we need to capture the advances of the marketplace. And if we make the wrong turn, in my opinion, on the pharmaceutical issue, we will devastate the future of medical health care services, not just Medicare, for the future of our country. And we will see a time not unlike what the good people of Canada and Mexico and other countries are dealing with.

So I believe that it is very important that the leadership provided by you and Senator Breaux and others on this issue stay very focused on the comprehensiveness and the integration of what we are doing here and not get sidetracked on, "well, let's do a little of this and do a little of that, and it will get us to the next election,

it will get us to the next year," because I don't think there is much margin for error anymore, Dr. Frist, in what we are doing here.

The most important domestic issue that this Congress and the country will deal with this year is health care. It is the one common-denominator issue for all of us. So I am, like many of us, Bill, grateful that you are here at this time in our history to help us through this.

Thank you. Mr. Chairman.

The CHAIRMAN. Senator Bayh.

STATEMENT OF SENATOR EVAN BAYH

Senator BAYH. Thank you, Mr. Chairman, for having this hearing. I appreciate your leadership. And, Bill, thank you for your leadership as well. I have been your colleague for just more than one year and in a short period of time have developed a great deal of respect for you and your work in this body. So thank you for your presence today.

I couldn't help but notice, Mr. Chairman, in the paper this morning with the submission of the President's budget there is a lot of good talk about the fiscal condition of the country. But as Senator Hagel was just mentioning, the good news is going to be temporary unless we address some of the long-term challenges that face our country particularly in the entitlement area, Medicare and Social Security.

We need to do this in a way that is not only going to protect our solvency, doctor, as you were mentioning, but ensure the quality of health care for all Americans. It seems to me that most of us want to arrive at the same destination. As Senator Wyden was mentioning, we have different approaches, but some of the same principles undergird them—comprehensiveness, a competitive, market-based system, with affordability and quality. There is naturally some tension there.

In that regard, I would like to get back to something that was alluded to previously both in your comments and by other members of the panel about the option for people in Medicare to stay with the current plan. Can you go back to that for just a moment? If someone chooses to stay with the current plan, does nothing change? They just continue to receive their benefits as they currently exist, and they are funded as they currently are funded?

Senator FRIST. Two issues. First of all, core benefits. The entitlement nature is guaranteed, whatever you choose to do. That is No. 1, the exact same benefits. Imagine it as a menu of plans. All of them have core benefits, just like our FEHBP. But in addition to the FEHBP model, the Federal Employees Health Benefit Plan model, you have another plan that you can choose from, which is today's coverage, straight fee-for-service. And you can choose today as a senior to stay right in that plan or to choose one of these other plans. If you had a heart transplant, you may want to choose one that has stronger coverage for long-term care or chronic care. So that is the choice component we haven't talked very much about, but you stay right in fee-for-service.

Senator BAYH. So if I am at a town hall meeting in my home State and somebody says, Senator, I have been watching these hearings, I don't care what you all do, but keep your hands off my

Medicare, I can assure them that they have the option of staying with the benefits they currently receive?

Senator FRIST. Yes, and it is a critical part. The biggest fear that seniors and individuals with disabilities have is we are going to take away something they have today. And built into this plan is the choice of staying with what you have today or choosing one of these more modern plans that offer preventive care and offer the other things which make sense.

Senator BAYH. Has any research been done or do we have any way to estimate what percentage of folks currently on or soon to go on Medicare will choose a different plan than the current setup?

Senator FRIST. The other panel members will be able to talk to that because they have really studied it and made the estimates.

Senator BAYH. They will get into the cost estimates on this, as well?

Senator FRIST. Yes, I am sure they will. A number of people looked at this over the last year, so exactly how many people go in and take advantage of it depends on a lot of incentives or disincentives that are given.

I don't know, John, if you want to comment.

Senator BREAU. If the Senator would yield, about 17 percent of the Medicare beneficiaries are in something other than fee-for-choice today, and it is growing, but it is about 17 percent today.

Senator BAYH. Very good. Well, Senator, again thank you for your leadership. This is a very complex and sometimes controversial topic, and I admire your courage for being willing to step up to the plate and lead on this issue.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Lincoln, do you have questions for Senator Frist?

Senator LINCOLN. Thank you, Mr. Chairman. I too want to add my compliments to the chairman for holding this hearing. I was watching you all on television before I got over here and, as Senator Collins said, I had a very eloquent opening statement and I would like to ask the chairman if I can submit it for the record.

The CHAIRMAN. It will be included in the record.

[The prepared statement of Senator Lincoln follows:]

PREPARED STATEMENT OF SENATOR BLANCHE LINCOLN

Thank you, Mr. Chairman and Senator Breau, for holding the first hearing of this year on such an important topic.

Most people agree that Medicare reform is needed because the health care system created in the 1960's is facing a number of problems. First, and foremost, is the fact that the system will run out of money in the near future unless something is done. On a positive note, we've achieved significant savings in the system due to vigilant efforts to weed out waste, fraud and abuse. Unfortunately, Congress reduced Medicare payments to providers through the Balanced Budget Act of 1997 and that has created a terrible burden on health care providers, especially hospitals.

Although Medicare provides coverage for many expenses, Medicare only covers about one-half of seniors' total health care expenses. Most beneficiaries incur significant out-of-pocket expenses to cover items like hearing aids, eye glasses and prescription drugs. In rural states, 54 percent of seniors do not have any prescription drug coverage. Low-income seniors living on fixed incomes are often faced with the dilemma of whether to buy food or pay for their prescriptions. This is simply unacceptable in a country as blessed and prosperous as ours.

I applaud Senator Breau and Senator Frist for leading a bi-partisan effort to create a framework for Medicare reform. This is not an easy task. Medicare is a complex system to understand and one that will cost our country more and more money

as baby boomers reach 65. By working together and setting our partisan differences aside, we can modernize the system and put it on sound financial footing for generations to come.

Thank you, Mr. Chairman, for time to make this statement and now I look forward to hearing from our expert witnesses.

Senator LINCOLN. Just a couple of points that I would like to make. I would like to compliment Senator Frist and Senator Breaux on all of their efforts. This is not an easy issue but it is one that we must tackle. You all put a lot of hard work and a lot of hours into this and I think we all very much appreciate that.

Fifty-four percent of our seniors in rural America have no prescription drug benefit. Coming from a predominately rural State, we are not quite at that number, but we are pretty close to it in Arkansas. In rural America our seniors are making choices between drugs and livelihood.

So I hope that as we look through these plans and we work through a solution that we keep in mind that rural America is different, that there are certain demographics and geographics that make us a little bit different, and I hope that we would take that into consideration as we look at these plans.

I would also like to just emphasize that as we look at these issues that we also include the voice of seniors. I know that as we have implemented the CHIP program, we have found some obstacles in implementation, and a lot of it, I think, is because we need to make them more accessible.

So as we develop this, I would just encourage the committee as well as you Senators that have really been in the forefront of developing these plans to remember that the voice of seniors is important so that not only do we provide the drug coverage, but we provide it in a way that seniors can use it and utilize it so that all of our efforts won't be in vain.

So thank you, Mr. Chairman. Thank you, Senator Frist, for all of your hard work, along with Senator Breaux.

The CHAIRMAN. Senator Frist, we had such an outstanding turn-out because you were our first witness. So I thank you for bringing all of our members out.

Senator FRIST. Thank you very much, and I appreciate the chance to begin this discussion where we will be able to pull down better and improved ideas.

The CHAIRMAN. I will turn to Senator Wyden, who wanted to make some opening comments. And I would ask David Walker and Dr. Wilensky and my constituent, Mr. Goesser, to come to the table while Senator Wyden is speaking.

STATEMENT OF SENATOR RON WYDEN

Senator WYDEN. Thank you, Mr. Chairman. I want to catch Senator Hagel before he leaves the room. I think Chuck Hagel was absolutely right in saying that health care is the dominant issue for our country. I would really go further and say that I think prescription drug coverage for seniors under Medicare is going to be the defining issue for this particular session of Congress because this is going to be a test of whether we can come together in a bipartisan way, and responsibly use the budget surplus to address the immense suffering and disability that we are seeing among the Nation's older people.

Frankly, I have watched this morning, and one-tenth of the U.S. Senate over the last hour is pretty darn close together. You have not heard a member of the U.S. Senate, for example, say they are in favor of price controls on prescription medicine. You haven't heard anybody on either the Republican or the Democratic side favor something that would involve a lot of cost-shifting. Some of the bills that have been advanced would in effect, allow Medicare to buy up the medicine and that just produces a lot of cost-shifting onto people who are 27 or 28 and having difficulty paying their drugs bills.

So I am encouraged by where this discussion is headed, and I only by way of opening statement want to make it clear that I favor addressing this in a comprehensive fashion. We can have a debate over principles. If comprehensive reform doesn't come to pass, I hope we don't let this opportunity go by. I believe what we have heard this morning indicates that you can have marketplace-oriented change in the Medicare program to add prescription drug coverage and bring both political parties and the administration together.

I think the key is to make sure that older people can get their medicine in an affordable way and we use marketplace forces. The fact is seniors get shellacked twice under current law. They don't get Medicare coverage, haven't since 1965, and then the big buyers, the HMOs and the health plans, go out and negotiate discounts. If you are an elderly widow in Arkansas or rural Oregon, when you walk into that pharmacy you pay a subsidy because the big buyers in cities can get discounts.

Now, Senators Breaux and Frist use marketplace forces to deal with that. Senators Snowe and Wyden do as well.

So I think we have a chance to come together in a bipartisan way. Finally, I want to commend, Mr. Chairman, the administration because they help us in two ways. First the administration helps by making sure that a significant portion of the non-Social Security surplus can be used for Medicare reform. And that is going to be key whether we are dealing with it in a comprehensive way or jump-starting it with prescription drugs.

And I also think that their approach using pharmaceutical benefit managers they can be reconciled with the approach that Breaux and Frist and Snowe and Wyden take. We are talking about unleashing private sector forces here.

Finally, I am very glad that Senator Lincoln talked about the need to involve seniors. Senator Snowe and I have been going to the floor. I have gone to the floor 23 times in the last few months to read accounts from seniors, most who have a couple of hundred dollars a month left to pay for all of their essentials when they are done with their prescriptions. So Senator Lincoln is right on target in terms of saying that we need to involve seniors.

I would ask unanimous consent, Mr. Chairman, to have introduced into the record a recent editorial endorsing the kind of approach that I am addressing. I appreciate the chance to make this statement.

[The editorial referred to follows:]

The New York Times

Designing a Medicare Drug Benefit

The recent decision by drug manufacturers to work with Congress and the White House to add a prescription drug benefit to Medicare this year is encouraging. It may even be what led President Clinton to forgo anticipated attacks on the industry's pricing practices in his State of the Union address. But it is premature to celebrate. Unless Congress passes the right kind of drug benefit — generous and properly designed — it could do future Medicare recipients more harm than good.

Drug manufacturers have long fought passing any Medicare drug plan unless it was part of an extensive redesign of the entire Medicare program, something few politicians think possible in an election year. The manufacturers feared that stand-alone plans, under which the government would buy drugs on behalf of 40 million retirees, would inevitably lead to price controls, squashing profits and innovation.

Policy experts point to another problem with stand-alone plans. Medicare desperately needs reform. Its costs are expected to double as a percentage of national income over the next several decades, yet Medicare benefits are skimpy. For example, they do not limit a beneficiary's out-of-pocket costs. Getting Congress to pass a major overhaul — adding expensive benefits and injecting enough competition into the program to control costs — will be difficult. Reformers want to hold out the bait of a drug benefit to lure political support.

If a drug benefit is passed separately, further reform of Medicare could be delayed indefinitely. So if Congress proceeds with a drug benefit now, the

coverage should be generous and designed in a way that would not interfere with future efforts to overhaul the program. A bipartisan bill sponsored by Senators Olympia Snowe, Republican of Maine, and Ron Wyden, Democrat of Oregon, provides one attractive option.

The Snowe-Wyden bill would create a board to oversee competition among private plans offering retirees a drug benefit. The sponsors leave unspecified the copayments, deductibles and other features of the drug plans — a flaw that Congress would need to fix. Under the proposal, the government would pay the entire premium for couples earning less than about \$15,000 a year and part of the premium for everyone else, with the subsidy declining as family income rises. The benefit would probably cost at least \$15 billion a year, perhaps 25 percent more than the benefit President Clinton has proposed.

The plan's hidden virtue is that the same structure that offers retirees a choice of competing drug plans can be expanded later to offer a choice of competing health plans, much as the Federal Employees Health Benefits Program offers a choice to members of Congress and other federal employees. That way Congress can pass a drug benefit today without fear that it would clash with efforts to reform the rest of the Medicare program tomorrow. The drug companies say the Snowe-Wyden plan is not their preferred choice, but they can live with it. Perhaps their turnabout will not prove an empty gesture offered merely to fend off election-year attacks by President Clinton and Congress.

The CHAIRMAN. I am ready to introduce our first panel now, or our second panel because Senator Frist was the first panel.

David Walker is Comptroller General of the General Accounting Office. Mr. Walker will give testimony about the financial stability and long-term outlook for the Medicare program.

We have asked Dr. Gail Wilensky, who is a senior fellow at Project HOPE, and international health foundation, to discuss what kinds of structural changes could be made to ensure long-term solvency of the Medicare program.

Stephen Goeser is administrator and CEO of Myrtue Memorial Hospital in Harlan, IA, and he is also chairman of the Association of Iowa Hospitals and Health Systems. We have asked him to address how we can bring equity to the Medicare program to maintain stability of the delivery of health care in rural America, particularly with hospitals. The witnesses will testify in that order.

Before we proceed, do you have an opening statement?

Senator JEFFORDS. I will just make it part of the record.

The CHAIRMAN. OK, Senator Jeffords, I appreciate that very much because we are running so far behind.

[The prepared statement of Senator Jeffords follows along with prepared statements of Senator Hagel, Senator Burns, and Senator Kohl:]

PREPARED STATEMENT OF SENATOR JEFFORDS

Good morning.

Mr. Chairman, I would like to thank you for holding this very important hearing this morning on the bipartisan Medicare reform proposal introduced by Senators Breaux and Frist. Medicare reform is, in my estimation, one of the most important issues that we will deal with this year and in the years to come. Congress made a commitment to the health and welfare of seniors in 1965, and we must not fail in securing Medicare for the baby boom generation and beyond.

I applaud Senators Breaux and Frist on crafting a bill that is, to my knowledge, the only truly bipartisan Medicare reform proposal introduced in this Congress. We should all salute the Medicare program and the health care it has provided for 35 years. But we also seek to improve and modernize the Medicare program so that older Americans receive better benefits, including prescription medicines, while maintaining their ability to choose their doctors.

Mr. Chairman, most of us acknowledge that the current benefits provided by Medicare are insufficient and need to be improved for all enrollees. Today's benefit packages were designed for a 1960s-era health care system, and they have not kept up with how that system has changed. With creation of the Medicare+Choice program, we made some headway improving Medicare with incremental changes, but that was not enough.

One of our witnesses today, Mr. Steve Goeser of Iowa, points out the imbalance of Medicare program payments per enrollee across the United States. A few of the States with the highest program payments receive over \$6,000 per enrollee, while those at the lower end receive just a little about \$3,000. Vermont receives only about \$3,600.

Unfortunately, States at the lower end cannot attract health plans with rich benefit packages, because the payment levels are too low. That will need to change during Medicare modernization.

Medicare coverage for prescription drugs will be the most important aspect of Medicare reform to most seniors, and I am glad that the bipartisan Breaux/Frist proposal includes a drug benefit. It is my intention to work as hard as I can to help finalize a Medicare reform bill this Congress. But if we are not able to achieve enactment of legislation this year, or even if we enact reform that is phased in over time, I am committed to pushing for enacting at least a stopgap, targeted bill that will help those seniors who need help the most—the low-income seniors who do not have employer-sponsored coverage and who are not eligible for Medicaid. That is why I have introduced several bills, which we could enact this year, that would help our most vulnerable Medicare beneficiaries get access to the prescriptions that they need to live longer, healthier lives.

This issue must be one of our top priorities this year, and I look forward to working with my colleagues to craft a sensible, workable solution that preserves Medicare for generations to come.

PREPARED STATEMENT OF SENATOR HAGEL

Good morning, Mr. Chairman. Thank you for calling this timely and important hearing to examine the need for comprehensive Medicare reform. As the primary provider of health care services for over 35 million seniors and 4 million disabled Americans, the Medicare program must be preserved and improved. Medicare needs to offer beneficiaries more options and benefits, such as prescription drug, eye, and dental coverage.

It is unfortunate that when Medicare was created in 1965, it did not cover outpatient prescription drugs. At that time, there were not many prescription drugs available, and medicines did not play the important role in patient health care that they do today. Now, thirty-five years after the creation of Medicare, pharmaceutical research has produced thousands of new medications that can greatly improve the quality of life, treat and prevent serious illness, and replace the need for surgery, hospitalization and other costly medical interventions. Today, when pharmaceuticals play such an important role in patient health—especially for senior citizens—it just doesn't make sense for Medicare to continue to exclude coverage of outpatient prescription drugs.

However, with the Medicare Trust Fund expected to become insolvent by 2015, adding a prescription drug benefit to the existing Medicare program would result in significantly higher premiums and hasten the program's collapse. In order to preserve Medicare and offer additional benefits, we must enact long-term structural reforms that fully address the program's solvency.

That is why I support the approach taken by S. 1895, the Medicare Preservation and Improvement Act, also referred to as "Breaux-Frist". I am an original cosponsor of this legislation, and commend the leadership and work of Senators John Breaux and Bill Frist, and the other members of the Bipartisan Commission on the Future of Medicare, from which this legislation was crafted.

The Breaux-Frist proposal would integrate prescription drug coverage into a comprehensive restructuring of the entire Medicare program. Under this approach, Medicare would be modeled after the same program Federal workers and Members of Congress use to obtain health care for themselves and their families. Not only would seniors be able to choose from a wide variety of health plans, but all seniors would have access to prescription drug coverage. As with the current Medicare Part B premium, Breaux-Frist would provide a 25 percent subsidy for everyone obtaining the new prescription drug benefit. Low income seniors would be eligible for an additional subsidy of as much as 100 percent for prescription drug coverage. Equally important, this approach ensures that seniors will be able to maintain any private insurance and prescription drug coverage they have now.

The legislation that my Senate colleagues and I have introduced will not only make drug coverage accessible to all Medicare beneficiaries, but it will also place the entire Medicare program on a stronger financial footing as our population ages. By streamlining Medicare and encouraging greater market-based participation, this legislation will give seniors more power over their health care decisions, guarantee affordable access to prescription drugs and other benefits, and ensure the program's solvency well into the next century.

While Breaux-Frist is presently the most responsible and achievable approach to strengthening Medicare and including a prescription drug benefit, it is only a beginning. We can make it better, and I look forward to hearing from today's panelists on how we can improve this legislation, and pass a bill that will preserve and improve Medicare.

Thank you Mr. Chairman.

PREPARED STATEMENT OF SENATOR BURNS

Thank you, Mr. Chairman. And thank you witnesses, for taking time to visit us on the Hill today. I appreciate your testimony.

Medicare helps fulfill America's promise to its elderly. While not a perfect system, Medicare offers Seniors the medical care they need. But now it is Medicare itself which needs attention and that is what brings us together today.

As we all know, the Balanced Budget Act of 1997 affected Medicare severely. In many urban areas around the country the cuts in Medicare reimbursement rates

could be absorbed by hospitals, home health agencies, and medical clinics. Rural states like Montana fared worse.

Much of what the Senate Finance Committee put together and included in the DC Appropriations bill last fall will bring needed relief to providers throughout the country. But those adjustments are just the beginning of what has happened. As we look at how to improve Medicare this year, we need to keep two groups of people in mind: small rural providers and, most importantly, Medicare beneficiaries.

Proportionately, Montana has one of the highest Senior Citizen populations. However, our home health agencies, rural clinics, and small hospitals are lucky if they run any margin at all. All too often medical facilities spend year after year running in the red. We need to make sure that rural providers are there so that when make the needed beneficiary reforms our small-town providers will be there to enact them.

It is time for an accessible, realistic prescription drug benefit in Medicare. But this benefit must be optional. We should not run the risk of forcing all Medicare recipients into a one-size-fits-all plan. Those who have made private arrangement for prescription drugs should be allowed, even encouraged, to maintain it.

The long-term solvency of the Medicare program must also be addressed. Those retiring today should not be left to wonder whether they will be covered tomorrow. Let us tread lightly with benefit expansion as long as we continue to stare system bankruptcy in the face.

I thank you again for coming here today. I truly hope that we can work together to refine and strengthen this program for the benefit of all Americans.

PREPARED STATEMENT OF SENATOR KOHL

Thank you, Mr. Chairman. I am pleased that you have called this hearing, which will focus on the future of one of our nation's most critical programs—the Medicare program. I also want to commend Senators Breaux and Frist for their hard work and dedication to ensuring that present and future generations can count on Medicare to serve their health care needs. While there may be disagreement over the Breaux-Frist plan, I greatly appreciate their efforts to move this debate forward.

When Medicare was created in 1965, it served as a lifeline for elderly Americans. For the first time, Medicare ensured that all of our nation's senior citizens would have access to the high-quality health services they needed and deserved.

Our country's health care delivery system has undergone tremendous changes since Medicare was first established. Today's patients benefit from exciting advances in medical technology and breakthroughs in the use of drugs to treat disease. Unfortunately, Medicare in its current form does not reflect many of these changes.

The most glaring example of this is the lack of adequate prescription drug coverage for Medicare beneficiaries. While 65 percent of beneficiaries have some form of prescription drug coverage, research has shown that beneficiaries still pay for half of their drug costs out-of-pocket. This can strain the resources of seniors at all income levels, and it is an even more serious problem for low-income seniors. Seniors should not have to choose between taking their medicines or buying food and paying rent. I strongly believe that prescription drug coverage must be included as part of any comprehensive Medicare reform proposal Congress considers.

In addition, as the Baby Boom generation begins to retire and the number of Medicare beneficiaries increases, we know that the financial solvency of Medicare will be in jeopardy if Congress does not act. While I believe we must seriously consider structural reforms to modernize the Medicare system, structural reform alone is unlikely to solve all of Medicare's financial problems. We must also look for ways to ensure that the dollars are there to meet the changing health care needs of seniors.

This hearing is a first step toward what I hope will be a real effort by Congress to address Medicare reform this year. I realize that there is much disagreement over how best to do that. I believe we must take a careful look at both the Breaux proposal and the President's proposal as we consider how best to preserve Medicare. Medicare is too important to become a partisan issue, and I look forward to working with my colleagues on both sides of the aisle to strengthen Medicare.

Again, thank you, Mr. Chairman, for holding this hearing today, and beginning this important dialog.

The CHAIRMAN. Mr. Walker.

**STATEMENT OF DAVID M. WALKER, COMPTROLLER GENERAL,
UNITED STATES GENERAL ACCOUNTING OFFICE, WASHINGTON, DC**

Mr. WALKER. Thank you, Mr. Chairman, I appreciate that, and members of the committee. I would like to compliment you for holding this hearing on such an important subject early in this session.

As you know, Mr. Chairman, I have an extensive statement, which I would like submitted for the record, and I would now like to briefly summarize that statement for the members' benefit.

I would like to focus my remarks on three topics: first, the nature, extent, and timing of Medicare's financing challenge; second, a proposed framework for assessing Medicare reform proposals; and, third, a few selected comments about the Breaux-Frist proposal, in particular.

Mr. Chairman, and Senators, we stand an important crossroads in our Nation's history. After 30 years of consistent annual deficits, we face projected budget surpluses as far as the eye can see. However, these are projections, and projections have inherent uncertainties. And one of the most critical inherent uncertainties associated with these projections is health care costs. In fact, the CBO, in its different projections, show that with a return to historical spending patterns and slightly higher Medicare costs, those surpluses could turn into deficits pretty quickly. So we must keep that in mind.

While we have a better fiscal situation in the short term, we know that surpluses represent both an opportunity and an obligation, an opportunity to better prepare us for the future, but yet there remains an obligation to begin to reform entitlement programs such as Medicare and Social Security in order to address the known demographic tidal wave that we know is coming.

We have known outyear challenges that have to be addressed, but first let's talk about Medicare. My first chart will demonstrate the solid line that is dipping down very rapidly represents the Trust Fund balance. The bars represent projected deficits, annual deficits for Medicare. As has been mentioned, Medicare has been in the red since 1992. It faced a deficit of about \$7 billion in 1999. It is projected to stay roughly the same and then escalate rapidly within the next 10 years, in particular after the baby-boomers start retiring early in this century. And you can see that the deficits are projected to escalate very dramatically.

Very importantly, rather than just looking at the micro of Medicare—and by the way, this is just Part A. You have got to consider Part B costs and the impact on overall spending and percentage of our economy. It is also important to look at the overall unified budget. As you know, the GAO has done a simulation for about the last 8 years that, based upon current law, based upon current policy, what is likely to happen to the overall fiscal situation of the Government 20 years out, 30 years out, 50 years out.

And the bottom is this: without fundamental changes in entitlement reform, we face a haircutting and an eventual total crowding-out of all discretionary spending, due primarily to escalating costs of Social Security and Medicare. And Medicare and health care costs are by far the biggest challenge in that regard.

Looking at Medicare requires tough choices between competing interests, and fundamental reform means that we have to debate such things as the difference between wants which are unlimited, needs which vary based on income and geographic area, et cetera, and what we as a Nation can afford, and there are practical limits to all three of those.

In that regard, and looking at Medicare reform, we have to address access, affordability, cost control, and quality assurance issues. Medicare reform also needs to address benefit provisions, program administration, and programming financing issues in order to take a comprehensive approach to needed reform. Solvency is just not enough. We also need to be focused on affordability, equity, adequacy, feasibility, and acceptance of any of these reforms.

The Breaux-Frist proposal includes a number of steps designed to increase provider competition, better sensitize beneficiaries to program costs, and increase beneficiary choice. It also includes targeted subsidies to a prescription drug benefit, as well as to catastrophic claims coverage. These represent meaningful first steps toward comprehensive Medicare reform and toward getting Congress out of micromanagement, in which it has been from time to time in the health care area.

More will ultimately have to be done, but it is important that we look at Medicare in a comprehensive fashion. There is a temptation to have dessert before we have had the main meal, and it is important that we recognize that the fundamental imbalance in Medicare is much greater than Social Security. And the sooner we get on with dealing with these challenges, the better off not only our Nation is going to be, but the better off our children and our grandchildren will be.

Mr. Chairman, again, I compliment you for having this hearing, also to compliment Senators Breaux and Frist and others who have proposals in this area. It takes leadership, it takes courage, it takes commitment, it takes persistence, but it is something that we need to do.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Walker, I thank you, and I also thank you for a very comprehensive statement that you made that will be inserted in the record which is the complete set of your remarks.

[The prepared statement of Mr. Walker follows:]

United States General Accounting Office

GAO

Testimony

Before the Special Committee on Aging, U.S. Senate

For Release on Delivery
Expected at 9:30 a.m.
Tuesday, February 8, 2000

MEDICARE

Program Reform and Modernization Are Needed But Entail Considerable Challenges

Statement of David M. Walker
Comptroller General of the United States



Mr. Chairman and Members of the Committee:

I am pleased to be here today as you discuss efforts to reform the administration, structure, and financing of Medicare—steps essential to maintaining the program's long-term sustainability and modernization. There appears to be an emerging consensus that substantive financing and programmatic reforms are necessary to put Medicare on a sustainable footing for the future. The long-term cost pressures facing this program are considerable. Fundamental program reforms are vital to reducing the program's growth, which threatens to absorb ever-increasing shares of the nation's budgetary and economic resources.

We stand at an important crossroads. After nearly 30 years of deficits, the combination of hard choices and remarkable economic growth has led to a budget surplus. We appear—at least for the near future—to have slain the deficit dragon. In its most recent projections, the Congressional Budget Office (CBO) shows both unified and on-budget surpluses throughout the next 10 years. While this is good news, it does not mean that hard choices are a thing of the past. First, it is important to recognize that by their very nature projections are uncertain. This is especially true today because, as CBO notes, it is too soon to tell whether recent boosts in revenue reflect a major structural change in the economy or a more temporary divergence from historical trends. Indeed, CBO points out that assuming a return to historical trends and slightly faster growth in Medicare would change the on-budget surplus to a growing deficit. This means we should treat surplus predictions with caution. Current projected surpluses could well prove to be fleeting, and thus appropriate caution should be exercised when creating new entitlements that establish permanent claims on future resources.

Moreover, while the size of future surpluses could exceed or fall short of projections, we know that demographic and cost trends will, in the absence of meaningful reform, drive Medicare spending to levels that will prove unsustainable for future generations of taxpayers. Accordingly, we need to view this period of projected prosperity as an opportunity to address the structural imbalances in Medicare, Social Security, and other entitlement programs before the approaching demographic tidal wave makes the imbalances more dramatic and more painful.

As the foregoing suggests, the stakes associated with Medicare reform are high for the program itself and for the rest of the federal budget, both now and for future generations. Current policy decisions can help us prepare for the challenges of an aging society in several important ways: (1) reducing public debt to increase national savings and investment, (2) reforming entitlement programs to reduce future claims and free up resources for other competing priorities, and (3) establishing a more sustainable Medicare program that delivers effective and affordable health care to our seniors.

In this context, I would like to make a few summary points before delving into the specifics of Medicare's financial health and a discussion of potential reforms.

- In addition to its sizable financial imbalance, Medicare is outmoded from a programmatic perspective. To address the need for an updated benefit package and adequate tools to

moderate program spending, proposals have been advanced that include benefit expansions and changes that make beneficiaries more cost conscious and incentives to make health care providers more efficient. This hearing focuses on one such proposal contained in S. 1895, entitled the Medicare Preservation and Improvement Act of 1999, which is commonly referred to as the Breaux-Frist proposal.

- Given the size of Medicare's unfunded liability, it is realistic to expect that reforms intended to bring down future costs will have to proceed incrementally. The time to begin the difficult but necessary steps to reclaim our fiscal future is now, when we have budget surpluses and a demographic "holiday" with retirees a far smaller proportion of the population than they will be in the future.
- Ideally, the unfunded promises associated with today's program should be addressed before or concurrent with proposals to make new ones, such as adding prescription drug coverage. To do otherwise might be politically attractive but not fiscally prudent. If benefits are added, policymakers need to consider targeting strategies that fully offset the related costs. They may also want to design a mechanism to monitor aggregate program costs over time and to establish expenditure or funding thresholds that would trigger a call for fiscal action. Our history shows that when benefits are attractive, fiscal controls and constraints are difficult to maintain. In addition, any potential program expansion should be accompanied by meaningful reform of the current Medicare program to help ensure its sustainability.
- To qualify as meaningful reform, a proposal should make a significant down payment toward ensuring Medicare's long-range financial integrity and sustainability—the most critical issue facing Medicare. The 1999 annual reports of the Medicare trustees project that program costs will continue to grow faster than the rest of the economy. Care must be taken to ensure that any potential expansion of the program is balanced with other programmatic reforms so that we do not worsen Medicare's existing financial imbalances. Proposals to reform Medicare should be assessed against the following criteria: affordability, equity, adequacy, feasibility, and acceptance. (See table 1.)

Table 1: Criteria for Assessing the Merits of Medicare Reform Proposals

Criterion	What this means for a proposal
Affordability	A proposal should be evaluated in terms of its effect on the long-term sustainability of Medicare expenditures
Equity	A proposal should be fair to providers and across groups of beneficiaries
Adequacy	A proposal should include resources that allow appropriate access and provisions that foster cost-effective and clinically meaningful innovations that address patients' needs
Feasibility	A proposal should incorporate elements that facilitate effective implementation and adequate monitoring
Acceptance	A proposal should be transparent and should educate provider and beneficiary communities about its costs and the realities of trade-offs required by significant policy changes

- People want unfettered access to health care, and some have needs that are not being met. However, health care costs compete with other legitimate priorities in the federal budget, and their projected growth threatens to crowd out future generations' flexibility to decide which of these competing priorities will be met. Thus, in making important fiscal decisions for our nation, policymakers need to consider the fundamental differences between wants, needs, and what both individuals and our nation can afford. This concept applies to all major aspects of government, from major weapons system acquisitions to issues affecting domestic programs. It also points to the fiduciary and stewardship responsibility that we all share to ensure the sustainability of Medicare for current and future generations within a broader context of providing for other important national needs and economic growth.
- Let's not kid ourselves—reforming Medicare is hard work. Health care spending accounts for one-seventh of the nation's economy, and Medicare is the nation's single largest health care payer. The program's beneficiary populations consist of roughly 35 million seniors and 4 million disabled individuals under age 65. The Health Care Financing Administration (HCFA) estimates that the program's billers—physicians, hospitals, equipment suppliers, and other providers of health services—number about 1 million.
- As the various reform options come under scrutiny, the importance of design details should not be overlooked. Our work on efforts to implement reforms mandated in the BBA is instructive regarding reform specifics. Three principal lessons can be drawn from recent experience: (1) The particulars of payment mechanisms largely determine the extent to which a reform option can eliminate excess government spending while protecting beneficiaries access to care. (2) Revisions to newly implemented policies should be based on a thorough assessment of their effects so that, at one extreme, they are not unduly affected by external pressures and premature conclusions or, at the other extreme, they remain static when change is clearly warranted. (3) For choice-based models to function as intended—that is, to foster competition based on cost and quality—consumers must have information that is sufficiently comparable.

At this time, I would like to discuss the competing concerns at the crux of Medicare reform in general, and to provide a conceptual framework for considering the various possible combinations of reform options in particular.

COMPETING CONCERNS POSE CHALLENGES FOR MEDICARE REFORM

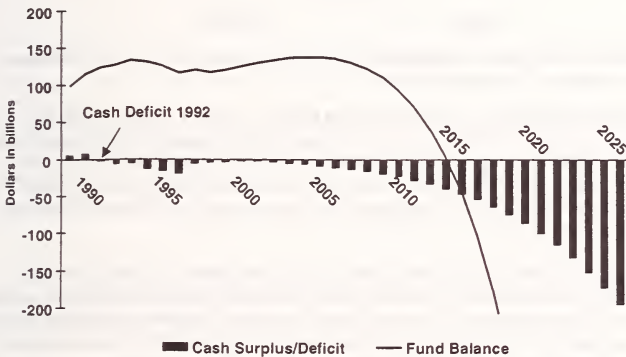
The current Medicare program, without improvements, is ill suited to serve future generations of seniors and eligible disabled Americans. On the one hand, the program is fiscally unsustainable in its present form, as the disparity between program expenditures and program revenues is expected to widen dramatically in the coming years. On the other, the program is outmoded in that it has not been able to adopt modern, market-based management tools, and its benefit package contains gaps in desired coverage compared with private employer coverage. Compounding the difficulties of responding to these competing concerns is the sheer size of the Medicare program—even modest program changes send ripples across the program's 39-

million-strong beneficiary population and the approximately 1 million health care providers that bill the program. Balancing the needs of all these parties requires hard choices.

Medicare Is Already in the Red

Unlike private trust funds that can set aside money for the future by investing in financial assets, the Medicare Hospital Insurance (HI) Trust Fund—which pays for inpatient hospital stays, skilled nursing care, hospice, and certain home health services—is essentially an accounting device. It allows the government to track the extent to which earmarked payroll taxes cover Medicare’s HI outlays. In serving the tracking purpose, annual trust fund reports show that Medicare’s HI component is, on a cash basis, in the red and has been since 1992. (See fig. 1.) Currently, earmarked payroll taxes cover only 89 percent of HI spending and, including all earmarked revenue, the fund is projected to have a \$7 billion cash deficit for fiscal year 1999 alone. To finance this deficit, Medicare has been drawing on its special issue Treasury securities acquired during the years when the program generated a cash surplus. Consequently, Medicare is already a net claimant on the Treasury—a threshold that Social Security is not currently expected to reach until 2014. In essence, for Medicare to “redeem” its securities, the government must raise taxes, cut spending for other programs, or reduce the projected surplus. Outlays for Medicare services covered under Supplementary Medical Insurance (SMI)—physician and outpatient hospital services, diagnostic tests, and certain other medical services and supplies—are already funded largely through general revenues.

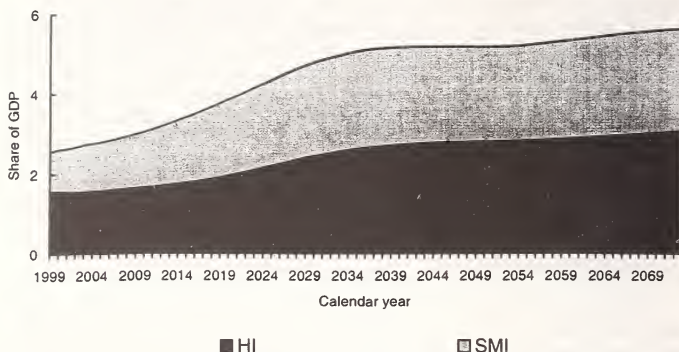
Figure 1: Financial Outlook of the Hospital Insurance Trust Fund, 1990 to 2025



Source: 1999 Annual Report, Board of Trustees of the Federal Hospital Insurance Trust Fund.

Without meaningful reform, the long-term financial outlook for Medicare is bleak. Together, Medicare's HI and SMI expenditures are expected to increase dramatically, rising from 12 percent in 1999 to more than a quarter of all federal revenues by midcentury. Over the same time frame, Medicare's expenditures are expected to double as a share of the economy, from 2.5 to 5.3 percent, as shown in figure 2.

Figure 2: Medicare Spending as a Percentage of Gross Domestic Product (GDP), 1999 to 2073



Source: 1999 Annual Report, Board of Trustees of the Federal Hospital Insurance Trust Fund and 1999 Annual Report, Federal Supplementary Insurance Trust Fund.

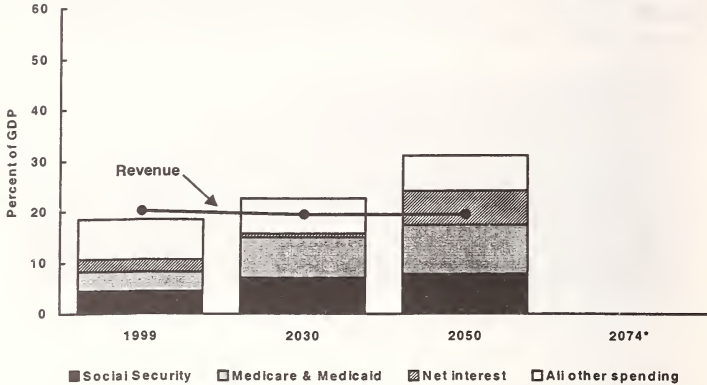
The progressive absorption of a greater share of the nation's resources for health care, like Social Security, is in part a reflection of the rising share of elderly population. Medicare's rolls are expanding and are projected to increase rapidly with the retirement of the baby boomers. Today's elderly make up about 13 percent of the total population; by 2030, they will comprise 20 percent as the baby boom generation ages and the ratio of workers to retirees declines from 3.4 to 1 today to roughly 2 to 1.

However, Medicare growth rates also reflect the escalation of health care costs at rates well exceeding general rates of inflation. Increases in the number and quality of health care services have been fueled by the explosive growth of medical technology. Moreover, the actual costs of health care consumption are not transparent. Third-party payers generally insulate consumers from the cost of health care decisions. In traditional Medicare, for example, the impact of the cost-sharing provisions designed to curb the use of services is muted because about 80 percent of beneficiaries have some form of supplemental health care coverage (such as Medigap insurance) that pays these costs. For these reasons, among others, Medicare represents a much greater and more complex fiscal challenge than even Social Security over the longer term.

When viewed from the perspective of the entire budget and the economy, the growth in Medicare spending will become progressively unsustainable over the longer term. Our updated budget simulations show that to move into the future without making changes in the Social Security, Medicare, and Medicaid programs is to envision a very different role for the federal government. Assuming, for example, that the Congress and the president adhere to the often-stated goal of saving the Social Security surpluses, our long-term model shows a world by 2030 in which Social Security, Medicare, and Medicaid increasingly absorb available revenues within the federal budget. Under this scenario, these programs would absorb more than three-quarters of total federal revenue. (See fig. 3.) Budgetary flexibility would be drastically constrained and little room would be left for programs for national defense, the young, infrastructure, and law enforcement.

Figure 3: Composition of Spending as a Share of GDP Under "Eliminate Non-Social Security Surpluses" Simulation

*The "Eliminate non-Social Security surpluses" simulation can only be run through 2066 due to the elimination of the capital stock.



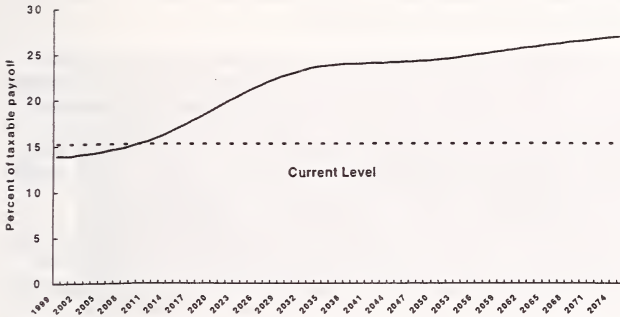
Notes:

1. Revenue as a share of GDP during the simulation period is lower than the 1999 level due to unspecified permanent policy actions that reduce revenue and increase spending to eliminate the non-Social Security surpluses.
2. Medicare expenditure projections follow the Trustees' 1999 intermediate assumptions. The projections reflect the current benefit and financing structure.

Source: GAO's January 2000 analysis.

When viewed together with Social Security, the financial burden of Medicare on future taxpayers becomes unsustainable, absent reform. As figure 4 shows, the cost of these two programs combined would nearly double as a share of the payroll tax base over the long term. Assuming no other changes, these programs would constitute an unimaginable drain on the earnings of our future workers.

Figure 4: Social Security and Medicare HI as a Percentage of Taxable Payroll, 1999 to 2074



Source: 1999 Annual Report, Board of Trustees of the Federal Hospital Insurance Trust Fund, and 1999 Annual Report, Board of Trustees of the Federal Old Age and Survivors Disability Insurance Trust Funds.

While the problems facing the Social Security program are significant, Medicare's challenges are even more daunting. To close Social Security's deficit today would require a 17 percent increase in the payroll tax, whereas the HI payroll tax would have to be raised 50 percent to restore actuarial balance to the HI trust fund. This analysis, moreover, does not incorporate the financing challenges associated with the SMI and Medicaid programs.

Early action to address the structural imbalances in Medicare is critical. First, ample time is required to phase in the reforms needed to put this program on a more sustainable footing before the baby boomers retire. Second, timely action to bring costs down pays large fiscal dividends for the program and the budget. The high projected growth of Medicare in the coming years means that the earlier the reform begins, the greater the savings will be as a result of the effects of compounding.

The actions necessary to bring about a more sustainable program will no doubt call for some hard choices. Some suggest that the size of the imbalances between Medicare's outlays and payroll tax revenues for the HI program may well justify the need for additional resources. One possible source could be general revenues. Such additional financing should be considered as part of a broader initiative to ensure the program's long-range financial integrity and sustainability.

What concerns me most is that devoting general funds to the HI trust fund may be used to extend HI's solvency without addressing the hard choices needed to make the whole Medicare program more sustainable in economic or budgetary terms. Increasing the HI trust fund balance

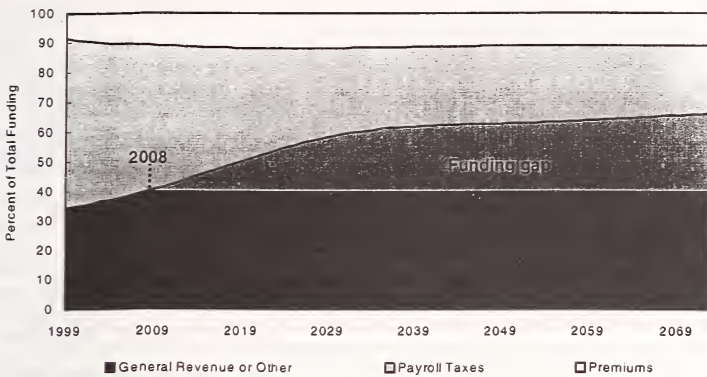
alone, without underlying program reform, does nothing to make the Medicare program more sustainable—that is, it does not reduce the program's projected share of GDP or the federal budget. From a macroeconomic perspective, the critical question is not how much a trust fund has in assets but whether the government as a whole has the economic capacity to finance all Medicare's promised benefits—both now and in the future.

If more fundamental program reforms are not made, I fear that general fund infusions would interfere with the vital signaling function that trust fund mechanisms can have for policymakers about underlying fiscal imbalances in covered programs. The greatest risk is that dedicating general funds to the HI program will reduce the sense of urgency that impending trust fund bankruptcy provides to policymakers by artificially extending the solvency of the HI program. Furthermore, increasing the trust fund's paper solvency does not address cost growth in the SMI portion of Medicare, which is projected to grow even faster than HI in coming decades.

The issue of the extent to which general funds are an appropriate financing mechanism for the Medicare program would remain important under financing arrangements that differed from those in place in the current HI and SMI structures. For example, under approaches that would combine the two trust funds, a continued need would exist for measures of program sustainability that would signal potential future fiscal imbalance. Such measures might include the percentage of program funding provided by general revenues, the percentage of total federal revenues or gross domestic product devoted to Medicare, or program spending per enrollee. As such measures were developed, questions would need to be asked about the appropriate level of general revenue funding as well as the actions to be taken if projections showed that program expenditures would exceed the chosen level.

For example, under the Breaux-Frist proposal, the HI and SMI trust funds would be merged and automatic general revenue financing would be limited to 40 percent of total program expenditures. Current spending projections show that absent substantive reform that addressed total program financing needs, this limit would be reached in less than 10 years. (See fig. 5.)

Figure 5: Projected Funding Gap Under a 40-Percent Cap in General Revenue Contributions



Source: 1999 Annual Report, Board of Trustees of the Federal Hospital Insurance Trust Fund and 1999 Annual Report, Federal Supplementary Insurance Trust Fund.

These data underscore the need for reform to include appropriate measures of fiscal sustainability as well as a credible process to give policymakers timely warning when fiscal targets are in danger of being overshot.

Long-Term Fiscal Policy Choices

Beyond reforming the Medicare program itself, maintaining an overall sustainable fiscal policy and strong economy is vital to enhancing our nation's future capacity to afford paying benefits in the face of an aging society. Decisions on how we use today's surpluses can have wide-ranging impacts on our ability to afford tomorrow's commitments.

As we know, there have been a variety of proposals to use the surpluses for purposes other than debt reduction. Although these proposals have various pros and cons, we need to be mindful of the risk associated with using projected surpluses to finance permanent future claims on the budget, whether they are on the spending or the tax side. Commitments often prove to be permanent, while projected surpluses can be fleeting. For instance, current projections assume full compliance with tight discretionary spending caps. Moreover, relatively small changes in economic assumptions can lead to very large changes in the fiscal outlook, especially when

carried out over a decade. In its January 2000 report,¹ CBO compared the actual deficits or surpluses for 1986 through 1999 with the first projection it had produced 5 years before the start of each fiscal year. Excluding the estimated impact of legislation, CBO says that its errors in projecting the federal surplus or deficit averaged about 2.4 percent of GDP in the fifth year beyond the current year. For example, such a shift in 2005 would mean a potential swing of about \$285 billion in the projected surplus for that year.

Although most would not argue for devoting 100 percent of the surplus to debt reduction over the next 10 years, saving a good portion of our surpluses would yield fiscal and economic dividends as the nation faces the challenges of financing an aging society. Our work on the long-term budget outlook illustrates the benefits of maintaining surpluses for debt reduction. Reducing the publicly held debt reduces interest costs, freeing up budgetary resources for other programmatic priorities. For the economy, running surpluses and reducing debt increase national saving and free up resources for private investment. These results, in turn, lead to stronger economic growth and higher incomes over the long term.

Over the last several years, our simulations illustrate the long-term economic consequences flowing from different fiscal policy paths.² Our models consistently show that saving all or a major share of projected budget surpluses ultimately leads to demonstrable gains in GDP per capita. Over a 50-year period, GDP per capita is estimated to more than double from present levels by saving all or most of projected surpluses, while incomes would eventually fall if we failed to sustain any of the surplus. Although rising productivity and living standards are always important, they are especially critical for the 21st century, for they will increase the economic capacity of the projected smaller workforce to finance future government programs along with the obligations and commitments for the baby boomers' retirement.

BBA Attempt to Moderate Medicare Spending Illustrates the Challenge of Reform

BBA reforms enacted in 1997 have begun to address certain outmoded programmatic shortcomings in Medicare by modernizing the program's pricing and payment strategies and by moving toward quality-based competition among health plans. The act's combination of structural reforms, constraints on provider fees, and increases in beneficiary payments have already contributed to slowing program spending. However, the full effects of these changes on providers, beneficiaries, and taxpayers will not be known for some time.

One significant change was BBA's creation of the Medicare+Choice program, which furthered the use of a choice-based model of providing Medicare benefits. Medicare+Choice expanded Medicare's managed care options to include, in addition to health maintenance organizations (HMO), health plans such as preferred provider organizations, provider-sponsored organizations, and private fee-for-service plans. By expanding consumer choice in the program, BBA provisions placed a dramatic new emphasis on the development and

¹*The Economic and Budget Outlook: Fiscal Years 2001-2010* (CBO, Jan. 2000).

²See *Budget Issues: Long-Term Fiscal Outlook* (GAO/T-AIMD/OCE-98-83, Feb. 25, 1998) and *Budget Issues: Analysis of Long-Term Fiscal Outlook* (GAO/AIMD/OCE-98-19, Oct. 22, 1997).

dissemination of comparative plan information to consumers to foster quality-based plan competition. Other BBA provisions were designed to pay health plans more appropriately than Medicare had done under the previous HMO payment formula.

BBA also made historic changes to traditional Medicare. It is gradually eliminating, for the most part, cost-based reimbursement methods and replacing them with prospective payment systems (PPS). The intent is to foster the more efficient use of services and to lower growth rates in spending for affected providers, replicating the experience for acute care hospitals after the implementation of Medicare's PPS for hospitals, which began in the mid-1980s. BBA mandated phasing in PPSs for skilled nursing facilities, home health agencies, hospital outpatient services, and certain hospitals not already paid under such arrangements.

The recent experience in attempting to implement BBA provisions is instructive. The outcry from providers to undo BBA reforms aimed at savings and efficiency was intense. In response, the Congress made refinements. Time will determine what more is needed to make Medicare a prudent and efficient purchaser of health care services. Initial provider reactions to CBO's new baseline do not bode well for attempts to remain fiscally disciplined. However, the expectations of special interests should not be given excessive weight in determining the appropriate level of Medicare spending.

DIMENSIONS OF REFORM INCLUDE BENEFIT EXPANSIONS AND FINANCING CHANGES

Concern continues to be voiced about the obvious gaps in protections for Medicare beneficiaries, in contrast to what is available for most individuals with private employer-based coverage. At the same time, competing concerns remain about the need to check Medicare's cost growth. In response, proposals for Medicare reform have addressed one or both of the following two major dimensions: expansion of Medicare's benefit package and cost containment through financing and other structural transformations.

Benefit Expansion Reforms

Two commonly discussed benefit expansions are the inclusion of an outpatient prescription drug benefit and coverage for extraordinary out-of-pocket costs, known as catastrophic or stop-loss coverage. Today's Medicare benefit package largely reflects the offerings of the commercial insurance market in 1965 when the program began. Although commercial policies have evolved since then, Medicare's package—for the most part—has not.³ For example, unlike many current commercial policies, Medicare does not cover outpatient prescription drugs or cap beneficiaries' annual out-of-pocket spending. Most beneficiaries augment their coverage by participating in the Medicaid program (if their incomes are low enough), obtaining a

³Some Medicare benefits have changed. For example, BBA added or expanded coverage for screening mammograms, prostate cancer screening tests, bone mass measurements, and several other screening or preventive services.

supplemental insurance policy privately or through an employer, or enrolling in a Medicare+Choice plan. About a third have no outpatient drug coverage. Consequently, many reform advocates believe that Medicare's basic benefit package should be brought into line with current commercial norms for active workers.

The inclusion of prescription drugs and stop-loss coverage each involve myriad options, and assessing the merit of these added benefits would depend on the specifics involved. For instance, how would these new program costs be shared between taxpayers and beneficiaries through premiums, deductibles, and copayments? Would subsidies be targeted to help low-income beneficiaries not eligible for Medicaid with these costs? Would incentives be needed to prevent a public drug benefit from crowding out private financing? The administration of the benefit raises other questions, such as who would set and enforce drug coverage standards among the private health plans participating in Medicare and, for traditional Medicare, how payment rates would be set.

Financing and Other Structural Reforms

In addition to benefit expansion, financing and structural elements of the following three general approaches appear in various proposals to reform Medicare:

- Fee-for-service modernization, which could enable traditional Medicare to act as a prudent purchaser and exercise better control over use of services.
- Medicare+Choice modernization, which would encourage plans to compete on cost as well as quality.
- A premium support system fashioned after the Federal Employees Health Benefits Program (FEHBP), which is designed to make beneficiaries sensitive to the cost implications of choosing a particular plan.

Table 2 highlights elements of each approach.

Table 2: Three Approaches to Medicare Financing and Structural Reforms

	Fee-for-service modernization	Medicare+Choice modernization	FEHBP-type premium support
Examples of changes mandated by BBA	<ul style="list-style-type: none"> • Prospective payment systems for home health agencies, skilled nursing facilities, and others 	<ul style="list-style-type: none"> • Health-based risk adjustment of rates • Annual enrollment and lock-in • Competitive pricing demonstration 	
Examples of proposed reforms	<ul style="list-style-type: none"> • Selective purchasing • Negotiated pricing • Case management for complex and chronic conditions • Utilization management • Medigap and beneficiary cost-sharing reforms • Expanded use of centers of excellence 	<ul style="list-style-type: none"> • Plan savings shared with program or beneficiaries • Competitive premium pricing 	<ul style="list-style-type: none"> • Premium based on offered or negotiated price • Beneficiary contribution based on plan cost • Traditional Medicare incorporated as competing plan

Fee-for-Service Modernization

BBA improved the efficiency of Medicare's traditional fee-for-service program by substituting prospective rates for its cost-based reimbursement methods. Nevertheless, Medicare is still not an efficient purchaser. Adequately adjusting its systems of administered prices and fees up or down to ensure beneficiary access or to capture potential savings as the market changes poses an overwhelming, if not impossible, challenge. Medicare largely remains a passive bill payer, exercising little meaningful control over the volume of services used. Proposals to modernize fee-for-service Medicare aim at providing flexibility to take advantage of market prices and introducing some management of service utilization. Below are several elements of this proposed type of approach.

Flexibility in setting payment rates. Preferred provider arrangements, whereby insurers select certain providers because of their willingness to accept lower fees or their efficient style of practice, have become commonplace in the commercial insurance market. By accepting negotiated or competitively bid fees that fall below the usual levels, selected providers and the beneficiaries using their services would be afforded certain advantages. The selected providers may experience increased demand, while beneficiaries using their services could be subject to lower cost-sharing. Comparable arrangements have been proposed for fee-for-service Medicare. Testing of this concept has been under way in the HCFA's Centers of Excellence demonstrations, where hospitals and physicians agree to provide certain procedures for negotiated all-inclusive fees. BBA also allowed for testing of competitive bidding for medical equipment and supplies, with high bidders being excluded from serving Medicare beneficiaries.

Increase in beneficiary cost-consciousness. While cost-sharing has been common in private insurance to make beneficiaries sensitive to the value and cost of services, it has been a cost-

containment tool largely unavailable to Medicare. Traditional Medicare includes some cost-sharing in the form of deductibles or copayments for services, but about 87 percent of beneficiaries are insulated from these costs by virtue of their eligibility for Medicaid or their enrollment in a supplementary insurance plan, such as Medigap. If reforms reduced these cost-sharing protections, beneficiaries would become more aware of the cost consequences of their health care decisions. At the same time, however, beneficiaries with high health care needs or limited resources could face financial hardships. Shielding these beneficiaries from such an outcome could involve placing an income-adjusted limit on beneficiary out-of-pocket expenses.

Utilization management. Private indemnity insurers have moved to incorporate certain utilization management techniques into their policies, such as prior authorization of some expensive services and case management for people with serious chronic conditions. Although such techniques are increasingly common among private insurers, Medicare has not incorporated them into its design.

Medicare+Choice Modernization

Medicare+Choice signaled a new phase in efforts to transform Medicare. Built on the program that allowed beneficiaries to enroll in participating managed care plans, Medicare+Choice sought to expand options available to beneficiaries and substantially changes plan payment methods. By raising payments in certain areas and allowing additional types of entities to contract with Medicare, Medicare+Choice was intended to boost plan participation and beneficiary enrollment.⁴ Payment changes were designed to adjust the per capita rates to more accurately reflect enrollees' expected resource use and slow the growth of spending over time. Following are key elements of the Medicare+Choice modernization approach.

Payments adjusted for beneficiary health status. Among other payment changes, BBA required HCFA to implement by January 1, 2000, a methodology to adjust plan payments to reflect the health status of plan members. Favorable selection—that is, the tendency for healthier beneficiaries to enroll in managed care plans—had resulted in payments that are higher than warranted. The new risk adjustment method developed for Medicare will more closely align payments with the expected health care costs of plans' enrollees. This alignment is expected to help produce the savings originally envisioned when managed care enrollment options were offered to Medicare beneficiaries and can foster competition among plans on the basis of benefits and quality rather than enrollment strategies.

Competition harnessed to benefit taxpayers. The Medicare+Choice program could be modified, through new legislation, to require that taxpayers and beneficiaries both benefit from health plan competition. Under the current Medicare+Choice program, taxpayers do not benefit from the competition among health plans. If a plan can provide the Medicare package of benefits for less than the Medicare payment, it must cover additional benefits, reduce beneficiary cost-

⁴Plan participation has fallen since BBA's Medicare+Choice provisions took effect. This decline may be more the result of external market forces than changes in Medicare's payment policy. See *Medicare Managed Care Plans: Many Factors Contribute to Recent Withdrawals, Plan Interest Continues* (GAO/HEHS-99-91, Apr. 27, 1999).

sharing, or both.⁵ Beneficiaries gain from competition among plans because these plans often offer enriched benefits—such as including coverage for outpatient prescription drugs or routine physical examinations—to increase market share. The program does not share in these gains, however, because it pays plans a formula-driven amount, even in fiercely competitive markets.

One modification the Congress could make would be to require that when payments exceed a plan's cost of services (including reasonable profit), part of the savings be returned to the program and the rest be used to fund additional benefits. Another alternative would be to set plan payments through competitive bidding. In fact, BBA mandates a competitive pricing demonstration. However, setting the parameters of a competitive pricing system is a formidable task. Furthermore, this payment-setting approach is probably best suited to urban areas with high concentrations of managed care members.

FEHBP-Type Premium Support

Although modernizing traditional Medicare and Medicare+Choice could improve the control of program spending, several incentives would remain unaltered. For example, beneficiaries would remain largely insulated from the cost consequences of their choices. They would not benefit directly from selecting plans that deliver Medicare-covered benefits less expensively because the premiums they pay might well remain constant. Program payments to plans would continue to be established administratively. To address this situation, proposals fashioned after the premium support model are designed to increase beneficiary sensitivity to the cost consequences of their choices and enhance quality-and-cost-based competition.

The two defining elements of an FEHBP-type of premium support are (1) the establishment of premium levels for plans through a competitive process and (2) the linking of beneficiaries' contributions to the premiums of the plans they join. This system makes transparent to beneficiaries which plans operate less expensively and can therefore charge lower premiums. The cost-slowness theory behind this approach works as follows: competition encourages efficiency because plans that can reduce costs can lower premiums and attract more enrollees. If these plans can attract beneficiaries with their lower premiums, enrollment in the more costly plans would drop, thus lowering the government's spending on Medicare. In practice, some caveats remain. Differences in premiums can reflect more than variation in efficiency. For example, plans may achieve savings through narrower provider networks that, while capable of providing Medicare-covered benefits, could cause beneficiaries inconveniences and delays in accessing services.

⁵Alternatively, plans can contribute to a stabilization fund that would allow them to provide additional benefits or lower fees in future years. Before BBA, health plans also had the option of accepting a lower capitation payment. In practice, plans preferred to add benefits to attract beneficiaries.

Breaux-Frist Proposal Includes Elements
of Modernization and Premium Support Approaches

The Breaux-Frist proposal includes elements from each of the structural and financing approaches discussed. Building on the premium-support concepts embedded in FEHBP, it replaces the current system in which each beneficiary pays a fixed monthly part B premium to the government and potentially an additional premium to a Medicare managed care plan. Under Breaux-Frist, each plan determines its own premium for a benefit package that must cover all benefits offered by traditional Medicare. The percentage of the premium paid by the beneficiary is set through a formula that compares a plan's premium with a national average of all plan premiums. Beneficiaries who join relatively inexpensive plans pay little or nothing. Those who join relatively expensive plans pay more. The system is intended to make beneficiaries more sensitive to the cost consequences of their decisions. Because plans would compete for market share, they would have an incentive to operate efficiently and attract beneficiaries by setting premiums that reflect that efficiency.

The proposal also seeks to modernize Medicare's benefit package by providing outpatient prescription drug and stop-loss benefits. Specifically, all participating entities would be required to offer a high-option plan that includes a specified amount of prescription drug coverage and protection against large out-of-pocket costs for the traditional Medicare benefits. The government would fully subsidize the purchase of a high-option plan for low-income beneficiaries and partially subsidize it for all others, thus providing a targeted benefit. Traditional fee-for-service Medicare, operated by HCFA, would exist as a standard option plan and remain available to all beneficiaries. The monthly amount charged to beneficiaries, analogous to the current part B premium, would be determined using the same formula applied to private plans. Alternatively, beneficiaries could purchase a high-option HCFA-sponsored plan.

IMPLEMENTING MEDICARE REFORM
INVOLVES MULTIPLE CHALLENGES

The challenge of implementing Medicare reforms must be respected. As we have noted before, to determine the likely impact of a particular policy, details matter. Design choices and implementation policies can affect the success of proposed reforms. In addition, because difficult choices tend to meet with opposition from affected parties, the will to stay the course is equally important for successful reform. Following are just a few of the issues germane to Medicare reform that remind us of the proverb, "The devil is in the details."

Adjusting Premiums to Avoid Putting
Beneficiaries and Plans at a Disadvantage

For proposals that include elements of premium support, the task of determining the government's contribution toward each plan's premium raises several technical issues. In general, the government's share is greater or smaller, depending on whether the plan's premium is below or above the average of all plan premiums. However, some plans can incur higher-

than-average expenses because they enroll a disproportionate number of more seriously ill and costly beneficiaries or because of local market conditions outside of their control. Unless the government contribution is adjusted for these circumstances, beneficiaries would face higher out-of-pocket costs and plans would be at a competitive disadvantage.

For example, most FEHBP-type reform proposals recognize the need to “risk adjust” the government contribution to reflect beneficiary health status. Such an adjustment enables plans to be fairly compensated when they enroll either healthier or sicker-than-average beneficiaries. The Medicare+Choice program is phasing in an interim risk-adjustment methodology based on the limited health status data currently available. The challenge, for Medicare+Choice or any premium-based reform proposal, is to implement an improved method that more accurately adjusts payments, does not impose an undue administrative burden on plans, and cannot be manipulated by plans seeking to inappropriately increase revenues.

An adjustment for differences in local medical prices is also desirable under a premium support system. Without it, premiums in high-price areas will tend to be above the national average. Adjusting the government contribution for input price differences can help ensure fair price competition between local and national plans and avoid having beneficiaries pay a higher premium, or higher share of a premium, simply because they live in a high-price area.

Finally, the use of medical services varies dramatically among communities because of differences in local medical practices. Under premium support approaches, plan premiums in high-use areas will likely exceed the national average. Whether, or to what extent, to adjust the government contribution for this outcome is a matter of policy choice. On the one hand, without an adjustment, beneficiaries living in high-use areas who join local private plans could face substantial out-of-pocket costs for circumstances outside of their control. Consequently, private plans in these areas might have difficulty competing with a HCFA-sponsored plan that charged a fixed national premium based on an overall average of medical service use. On the other hand, there have been longstanding concerns about unwarranted variations in medical practice. By not adjusting the government contribution for utilization differences, financial pressures could encourage providers to reduce inappropriate levels of use.

Determining the Role of the Entity That Administers the Program

Medicare’s administrative functions include the oversight of plans’ contracts. In today’s Medicare program, this function is performed by HCFA; in FEHBP, by the Office of Personnel Management; under Breaux-Frist, by a quasi-independent Medicare board.

Whatever the administrative entity is under Medicare reform, the following are questions that policymakers will want to consider. First, how will the administrative entity’s mission be defined? Will the emphasis be on controlling costs, protecting beneficiaries, maximizing choice, or some combination of these goals? Policy choices would flow from the stated mission. Second, how much independence would be permitted to the administrative entity to carry out its mission? Would it be appropriately shielded from the pressure exerted by special

interest groups? Third, how would the administrative entity hold plans accountable for meeting Medicare standards? Would it rely chiefly on public accountability, in which the process and procedures for compliance are clearly defined and actively monitored, or on market accountability, by providing comparative information on competing plans and letting beneficiary enrollment choices weed out poor performers?

Incorporating Traditional Medicare as a Competing Plan

Incorporating traditional Medicare as another competing plan raises a number of questions. How much flexibility can be granted to traditional Medicare, which today enrolls 83 percent of all Medicare beneficiaries? Will it be able to adopt modern management techniques—such as selectively contracting with providers—given its potential market power? What will it mean for a public plan to be self-sustaining and self-financing? Can it generate and retain reserves as a protection against future losses? How will losses be managed? The insolvency of traditional Medicare, which may continue to enroll the majority of beneficiaries and may be the only plan serving many areas of the country, is not acceptable. The dilemma of how to guarantee traditional Medicare's solvency in the context of an FEHBP-type premium support system needs to be addressed.

CONCLUDING OBSERVATIONS

In determining how to reform the Medicare program, much is at stake—not only the future of Medicare itself but also assuring the nation's future fiscal flexibility to pursue other important national goals and programs. Mr. Chairman, I feel that the greatest risk lies in doing nothing to improve the program's long-term sustainability or, worse, in adopting changes that may aggravate the long-term financial outlook for the program and the budget.

It is my hope that we will think about the unprecedented challenge facing future generations in our aging society. Relieving them of some of the burden of today's financing commitments would help fulfill this generation's fiduciary responsibility. It would also preserve some capacity to make their own choices by strengthening both the budget and the economy they inherit. While not ignoring today's needs and demands, we should remember that surpluses can be used as an occasion to promote the transition to a more sustainable future for our children and grandchildren.

General fund infusions and expanded benefits may well be a necessary part of any major reform initiative. Updating the benefit package may be a necessary part of any realistic reform program to address the legitimate expectations of an aging society for health care, both now and in the future. Such changes, however, need to be considered as part of a broader initiative to address Medicare's current fiscal imbalance and promote the program's longer-term sustainability. In addition, the Congress should consider adequate fiscal incentives to control costs and a targeting strategy in connection with any proposal to provide new benefits such as prescription drugs.

I am under no illusions about how difficult Medicare reform will be. The Breaux-Frist proposal addresses the principal elements of reform, but many of the details need to be worked out. Those details will determine whether reforms will be both effective and acceptable—that is, seen as guaranteeing the sustainability and preservation of the Medicare entitlement, a key goal on which there appears to be consensus. Experience shows that forecasts can be far off the mark. Benefit expansions are often permanent, while the more belt-tightening payment reforms—vulnerable to erosion—could be discarded altogether. Recent experience implementing BBA reforms provides us some sobering lessons about the difficulty of undertaking reform and the need for effectiveness, flexibility, and steadfastness. Effectiveness involves collecting the data necessary to assess impact—separating the transitory from the permanent and the trivial from the important. Flexibility is critical to make changes and refinements when conditions warrant and when actual outcomes differ substantially from the expected ones. Steadfastness is needed when particular interests pit the primacy of their needs against the more global interest of making Medicare affordable, sustainable, and effective for current and future generations of Americans. This makes it all the more important that any new benefit expansion be carefully designed to balance needs and affordability, both now and over the longer term.

The bottom line is that surpluses represent both an opportunity and an obligation. We have an opportunity to use our unprecedented economic wealth and fiscal good fortune to address today's needs but an obligation to do so in a way that improves the prospects for future generations. This generation has a stewardship responsibility to future generations to reduce the debt burden they will inherit, to provide a strong foundation for future economic growth, and to ensure that future commitments are both adequate and affordable. Prudence requires making the tough choices today while the economy is healthy and the workforce is relatively large. National saving pays future dividends over the long term but only if meaningful reform begins soon. Entitlement reform is best done with considerable lead time to phase in changes and before the changes that are needed become dramatic and disruptive. The prudent use of the nation's current and projected budget surpluses combined with meaningful Medicare and Social Security program reforms can help achieve both of these goals.

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Mr. Chairman and Members of the Committee, this concludes my prepared statement. I will be happy to answer any questions you may have.

GAO CONTACTS AND ACKNOWLEDGMENTS

For future contacts regarding this testimony, please call Paul L. Posner, Director, Budget Issues, at (202) 512-9573 or William J. Scanlon, Director, Health Financing and Public Health Issues at (202) 512-7114. Other individuals who made key contributions include Linda F. Baker, James C. Cosgrove, Hannah F. Fein, and James R. McTigue.

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The CHAIRMAN. Dr. Wilensky.

STATEMENT OF GAIL R. WILENSKY, JOHN M. OLIN SENIOR FELLOW, PROJECT HOPE, BETHESDA, MD

Ms. WILENSKY. Thank you, Mr. Chairman and Members of the Aging Committee. My name is Gail Wilensky. I am here today as the John Olin Senior Fellow at Project HOPE. As many of you know, I also am the chair of the Medicare Payment Advisory Commission and a former Administrator of the Health Care Financing Administration. But I would like to emphasize that I am not here in any official capacity today, but rather as a health policy analyst. I am also here to support the Breaux-Frist proposal, and I would like to explain why I believe this is a step in the right direction.

As we have heard, there is a continuing need to reform Medicare. There are solvency and financial pressures that you have heard about. I would like to just elaborate on one point about the 2015 insolvency date that David Walker mentioned for Part A of Medicare, and that is that this depends on achieving some razor-thin surpluses in each of the first 5 years of the decade that we are now in. If anything should happen to either decline wage revenue which feeds into the fund or to increase spending out of the fund, even those razor-thin surpluses could go away. So while things look very good as we speak today, we need to understand just how fragile these estimates actually are.

But it is not just a matter of money. The fact is the current benefit structure of Medicare is unfair and inadequate. You have heard that. Prescription drug benefits are one issue, catastrophic coverage is another. But the inequity is also something that many of you have spoken to me in my current capacity at MedPAC and in my former capacity at HCFA, and that is about the geographical cross-subsidies that go on in the existing program. There is a tremendous amount of cross-subsidy from conservative, low-cost areas to aggressive, high-cost areas in the country, and it has produced some very unfair spending differences.

Now, I would like to explain why I think that premium support models, in general—the Breaux-Frist bill is a good example of one—are a reform vehicle which addresses many of these issues. I have a few concerns. I want to touch on them at the end. I don't regard these as fatal flaws, but just issues that I think both Senators are aware of, and to remind you that you may want to take on some of these issues early on or you may want to start this reform movement and then take them on.

The reason that I think that the Breaux-Frist bill and premium support models in general are better is that they reward seniors for choosing efficient, low-cost health care plans. But very importantly, as has been mentioned, they also allow seniors to remain in traditional fee-for-service plans if that is what they choose, either with the core benefits that they now have or to go into a high-option traditional Medicare program which would also include prescription drugs. It also provides, importantly, better incentives for physicians and other people who provide health care services to seniors.

Now, I am aware that there are many of your colleagues, not necessarily on this committee but in other parts of the Senate, as well as in the House, who are concerned about some of the issues

relating to premium support programs, whether or not we can actually carry this transformation out.

I would like to remind you that the most vexing issues concerning premium support are actually present right now in the current Medicare program which includes traditional Medicare and the Medicare risk programs—how to educate seniors about choices that they will be asked to make, how to make risk adjustment payments that fairly represent the health status differences that may be not only between the fee-for-service and the risk programs, but across various risk programs. So while I don't want to underestimate the difficulty of some of these issues, I would like to remind you that they are not confined to moving to a premium support world, but rather we face them right now.

Any major Medicare reform will require a number of steps, and because of that, I think if there is any way possible that you can move forward now, it would be very wise to do so. Building an infrastructure will take time. The time to start best is right now.

I would also like to remind you that while we hear that many of today's seniors are low-, low-middle income, and of course there is much truth to that, we also need to remember that we will be having a senior population in the future when the baby-boomers retire which may look quite different. Many of the people who will be retiring after 2010 will have 401(k) plans, retirement plans of various sorts, and pensions that they and their employers have contributed to. Women for the most part will have worked their full adult life. We ought not to make a reform based only on today's seniors, but also on tomorrow's seniors.

We will need some different institutional structures. A Medicare Board separate from the Health Care Financing Administration to oversee and perhaps to negotiate with plans is a very important institutional change. I can talk about that more later with you if you would like. I think you need to be careful exactly how much power you want to provide this board as well.

I think you will also need to have more flexibility given to HCFA if you truly want to have a modernized fee-for-service plan. HCFA will have to act in a more accommodating way that it has had, but frankly the Congress will have to delegate more power and flexibility to HCFA than I have seen over the last decade.

Now, just a moment about some problems that I think remain, some of which could be easily accommodated, others not so easily. The first is there is no, as I have read the bill, stop-loss protection for prescription drugs; there is for current benefits. I think that could be and should be changed either with a single stop-loss or two separate that converge over time.

The second is I think we ought not to wait until 2003 to do something for seniors, which is what I read in the bill. My preference is to start help with the lowest-income seniors right now. I am sure we will talk about other strategies such as the one that Senator Wyden has raised, but I worry about waiting until 2003 for the very lowest-income seniors.

And, finally, there are a number of very hard issues that remain, the future financing of Medicare, for one, Senator Bunning, graduate medical education for a second, and what, if anything, we

want to do about the age of eligibility and income relating to Medicare.

Thank you.

The CHAIRMAN. Thank you, Dr. Wilensky.

[The prepared statement of Ms. Wilensky follows:]

THE NEED AND DIRECTION FOR
MEDICARE REFORM

Testimony

Presented To

THE SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

By

Gail R. Wilensky, Ph.D.

John M. Olin Senior Fellow, Project HOPE

On

February 8, 2000

Mr. Chairman and members of the Aging Committee, thank you for inviting me to appear before you. My name is Gail Wilensky. I am a John M. Olin Senior Fellow at Project HOPE, an international health education foundation and I chair the Medicare Payment Advisory Commission. I am also a former Administrator of the Health Care Financing Administration. My testimony today reflects my views as an economist and a health policy analyst as well as my experiences running HCFA. I am not here in any official capacity and should not be regarded as representing the position of either Project HOPE or MedPAC.

I am here to support the Breaux-Frist proposal. Their proposal, the Medicare Preservation and Improvement Act of 1999, is an example of the direction of reform Medicare needs to take. Although I believe there are some problems that remain with the proposal, which I summarize in my testimony, the changes move Medicare in the right direction by providing better incentives to seniors and providers and by linking a new drug benefit to overall reform.

Under the Breaux-Frist proposal, seniors could choose from competing health plans to obtain their health services. Seniors would have the option of selecting a basic health plan, which covers current Medicare benefits, or a high option plan that also includes coverage for outpatient prescription drugs and a stop-loss

benefit. In addition to competing private standard and high option plans, there would also be a HCFA-sponsored standard and high option plan, thus allowing seniors who wished to, the ability to remain in traditional Medicare. Low income populations (seniors under 135% of the poverty line) would get full Federal funding for the lowest-cost high option plan in their area. Other low-income seniors would get a sliding scale subsidy for drug benefits.

The Need for Reform

Medicare's popularity as a social program notwithstanding, the program is in major need of reform. Although Medicare solved the primary problem it was designed to address, ensuring that seniors had access to health care, there are a variety of problems with Medicare as it is currently constructed.

Much of the motivation for Medicare reform has been financial. Medicare, as it is currently structured, is partially dependent on a Part A trust fund that is currently projected to be depleted of funds just as the pressure of the baby boomers retirement starts to be felt. The April 1999 report of the Social Security Trustees, the latest official estimates, moved the date of depletion from 2010 to 2015. This estimate, however, is very fragile. The additional five years of Part A solvency are based on razor-thin surpluses over several years that could easily disappear if Part

A expenditures increase slightly faster than anticipated or wage tax revenue grows slightly slower than anticipated. In addition, the pressure on general revenues from Part B growth will continue although this is less observable since Part B is not funded by a stand-alone trust fund. Although the economy is remaining strong, with substantial budget surpluses being projected over the next ten years, the realized surplus will be highly dependent on the amount which discretionary spending is allowed to grow.

However, the motivation for Medicare reform is and should be more than financial. Traditional Medicare is modeled after the indemnity insurance plans that dominated the way health care was organized and delivered in the 1960's. The benefit package also reflects the 1960's, not covering outpatient pharmaceuticals or protection against very large medical bills.

Because of the limited nature of the benefit package and, at least until recently, the restricted nature of plan choices allowed under Medicare, almost all seniors supplement traditional Medicare. The use of this two-tiered insurance strategy has had important consequences for both seniors and for the Medicare program. For many seniors, it has meant substantial additional costs, with annual premiums varying between \$1000 and \$3000 or more.

The supplemental plans have also meant additional costs for Medicare. By filling in the cost-sharing requirements of Medicare, the plans make seniors and the providers that care for them less sensitive to the costs of care, resulting in the greater use of Medicare-covered services and thus increased Medicare costs.

In addition to concerns about the incentives associated with Medicare, there are also issues of equity. The amount Medicare spends on seniors varies substantially across the country, far more than can be accounted for by differences in the cost of living or differences in health status among seniors. Since seniors and others pay into the program on the basis of income or wages and pay the same premium for Part B services, this results in substantial cross-subsidies from people living in low cost states and states with conservative practice styles to people living in higher cost states and states with aggressive practice styles.

The Direction of Reform

I believe a program modeled after the Federal Employees Health Benefits Program or what is now generically referred to as a premium-support program, such as the Breaux-Frist proposal, would provide a better structure for Medicare. Such a program could produce a more financially stable and viable program, and would provide better incentives for seniors to choose efficient plans and/or providers and

better financial incentives for physicians and other health care providers to produce high-quality, low-cost care. This type of program would allow seniors to choose among competing private plans, including a modernized fee-for-service Medicare program, for the plan that suited their needs. It also includes outpatient prescription drug coverage as part of overall Medicare reform.

I am well aware that the premium support model remains controversial among some Members of Congress. However, I think it is important that committee members understand that many of the most vexing issues that need to be resolved for a premium support program must also be resolved for the current Medicare program. This will remain true as long as the Medicare program includes a traditional fee-for-service benefit and a variety of Medicare replacement programs. These include such issues as risk adjustment, providing understandable and user-friendly information to seniors, assuring that quality care is being delivered and providing safeguards for frail and vulnerable populations.

Some are raising questions about the difficulties surrounding the Medicare+Choice program and what that portends for premium support. Although the Medicare+Choice program continues to grow, the growth rate has slowed down dramatically.

Understanding the problems being experienced by Medicare+Choice may help to prevent them from occurring in a premium support program. In some cases, plans just made bad business decisions. They went into too many markets or tried to enter markets where they were unable to form networks. Plans also found special problems entering rural areas, especially those with a single hospital or a few dominant provider groups. Finding ways to make more plan choices available in rural areas will clearly need more effort.

But other problems reflect actions by the government that can and should be addressed. There is substantial uncertainty about the “rules of the road” – new regulations and requirements, reimbursement changes, changing models of risk adjustment, etc. Equally disturbing is the growing differential in spending rates for Medicare services in traditional Medicare versus spending in Medicare replacement plans. These are issues that need to be resolved for Medicare+Choice as well as a premium support model.

Getting From “Here” to “There”

Historically, changes in Medicare reimbursement policy and structure have been phased in over several years. This has helped to cushion the disruption that abrupt changes could cause. It also makes sense to consider phasing-in changes in the

structure or organization of a reformed Medicare program that requires substantially different roles for government or substantially different roles for the administrative institutions supporting the program such as exists with premium support. Any interest in experimenting with various strategies for reform or the administrative structures supporting reform makes it even more urgent that we begin the process now.

Concerns have been raised about instituting significant changes in a program involving the elderly. Many of today's seniors have had little experience with health plans other than fee-for-service indemnity plans, many seniors have modest incomes and some have little education. Whatever changes are made to the Medicare program may need to be modified for at least some subsets of the existing seniors population. Some groups of seniors may need to be excluded from any change.

Because of the difficulties that come with changing programs involving seniors, it is important that we establish now where we want to go with a reformed Medicare program.

It is also important to understand that the people who will be reaching age 65 or over the next decade as well as the baby-boomers have had very different

experiences relative to today's seniors. Most of them have had health plans involving some forms of managed care, many of them have had at least some experience choosing among health plans, most have had more education than their parents and many will have more income and assets. The biggest change involves the women who will be turning 65. Most of these women will have had substantial periods in the labor force, many will have had direct experience with employer-sponsored insurance and at least some will have their own pensions and income as they reach retirement age. This means we need to think about tomorrow's seniors as a different generation, with different experiences, with potentially different health problems, and if we start soon, with different expectations.

The Administrative Structure Supporting a Reformed Medicare

At least two major administrative issues need to be addressed. The first involves using a Medicare Board as the major administrative structure supporting a premium support type of program. The second involves the potential role of the Health Care Financing Administration in running a modernized fee-for-service Medicare program.

I support the notion of a separate Medicare Board that would oversee and perhaps negotiate with private plans and the traditional Medicare program. As proposed,

the most important functions of such a Medicare Board would be to review and approve benefit packages, to negotiate premiums, make payment modifications (such as risk adjustment), direct open enrollment periods and to provide information about plan choices. Giving the Board the ability to negotiate premiums and specify benefits runs the risk of making the Medicare Board a super HCFA and should be considered carefully. The oversight does not pose this risk..

While I think it is appropriate and proper that the individuals who have been involved in administering the Medicare+Choice program at HCFA be moved to the Board, it is important to have a Board that is separate from HCFA and with leadership from outside of HCFA. It would be desirable to include people with experience administering the FEHB program, the CalPERS program and some of the more comparable programs from the private sector.

Among the many reasons a separate Medicare Board is desirable is that the mind-set of HCFA is focused on running a publicly administered, price-setting, fee-for-service system. The functions and roles for government in running and monitoring a premium support system are so fundamentally different from the experiences and mind-set of HCFA personnel that it would detract from rather than enhance the successful operations of a premium-support program.

A more difficult issue is whether HCFA or any governmental entity could administer a modernized fee-for-service system that competes effectively with privately administered plans. A series of changes would be needed to modernize the traditional Medicare program. These include the use of selective contracting, centers of excellence, disease management programs, best practice programs, variations in benefit structures and other changes that are commonplace in the better-run private sector plans.

The question in my mind is whether the Congress will allow HCFA the flexibility that would be needed to run such a program and whether the Congress and the Administration will provide HCFA with the resources needed to carry out such a task. History is not encouraging on either of these issues.

If HCFA or any other governmental agency is to run a modernized fee-for-service program, Congress will need to change its relationship with HCFA and retreat from its very micro-prescriptive directives. This would require both changes in statute and changes in attitude. It would also require changes in attitude and behavior by the employees of HCFA. Demonstration and/or adoption of promising ideas from the private sector have been painfully slow to be undertaken by HCFA. Some of this slowness may be caused by political difficulties associated with these strategies, such as the selective exclusion of providers, or by

a lack of appropriate funding. But too often it appears to be the results of bureaucratic inaction and indecision.

An alternative to a publicly-administered, modernized fee-for-service Medicare program is the use of competitively-procured, private fee-for-service plans. These plans could be bid out on a risk basis at a national, regional or state level with plans using administered pricing if they chose to do so.

The attraction of the privately administered fee-for-service plans is that they can introduce changes in local markets that HCFA may not be able to do. But for many people, this is also the fundamental drawback of the privately administered plans. The public oversight and control of a publicly administered plan provides a sense of protection that will be difficult to ignore and at least to me, the political objections likely to result from eliminating a publicly administered traditional Medicare program, seem overwhelming.

This means that if there is to be a publicly-administered, modernized fee-for-service component to a premium support program, which I think is both desirable and politically necessary, Congress will need to change its relationship with HCFA and grant it more flexibility than it has done in the past. In return, HCFA will need to be more responsive, more pragmatic and more creative in its behavior.

Unresolved Issues and Other Remaining Problems

While the Breaux-Frist proposal represents an important step towards reforming the Medicare program, there are some problems with the proposal in the short term and some issues that have not yet been addressed but which will need to be addressed in the long term.

There are at least two important issues that should be addressed in the short term. The first is the inclusion of a stop-loss provision for outpatient prescription drugs. The easiest and most appropriate way to address this issue is to provide a single, somewhat higher stop-loss provision that includes both current Medicare benefits and prescription drugs although it would be possible to begin with two separate stop-loss provisions and have them converge into a single measure over time.

A second issue involves the use of a temporary prescription drug benefit for the lowest income populations until such time as the Congress is ready to pass and/or implement major Medicare reform. This could include a block grant program loosely based on the SCHIP model, a prescription drug benefit limited to the Qualified Medicare Beneficiary (QMB) and Selected Low Income Medicare Beneficiary (SLMB) populations, a block grant program to states to develop or expand state pharmacy assistance programs or some other model.

There are a number of other areas of concern, some of which were deliberately not included in this piece of legislation. Examples include the treatment of funding for graduate medical education, the appropriate age of eligibility, reform of the Medigap market and so forth. Questions have also been raised as to whether there are sufficient safeguards for rural areas. While all of these are legitimate questions, they can be addressed with subsequent legislation or by amending the current proposal if the Congress is ready to take on all of these issues at the present time.

Despite these shortcomings, the Breaux-Frist proposal represents an important step in the overall reform of the Medicare program.

Let me summarize my points as follow:

There is a continuing need to reform Medicare

- ◆ Solvency and financial pressures will continue as important issues
- ◆ The current benefit structure is inadequate and unfair, existing geographic cross subsidies are also unfair

A premium support model, such as the Breaux-Frist proposal, is a reform vehicle to address these issues

- ◆ It rewards seniors choosing low-cost, efficient plans; allows seniors to choose plans that best suit their needs; and provides better incentives to physicians and other providers
- ◆ Many of the most vexing issues of premium support are also present with the current combination of fee-for-service Medicare and Medicare replacement programs.

Medicare reform will require a series of changes

- ◆ Reform should start now; building the infrastructure will take time
- ◆ Future seniors will be different from today's seniors in terms of work experiences, health plan experiences, income and education

Premium support model requires a different institutional structure

- ◆ A Medicare Board, separate from HCFA, to oversee and perhaps to negotiate with plans although providing this much power to the Board should be considered carefully
- ◆ A modernized FFS Medicare requires a different mind-set from HCFA and a more flexible relationship with Congress

Some problems remain with the Breaux-Frist legislative proposal

- ◆ There is no stop-loss protection for drug spending, even after a phase-in
- ◆ There is no additional help for low income seniors until 2003
- ◆ Several hard issues remain unresolved--GME, Medigap, future financing, etc.

The CHAIRMAN. Mr. Goeser.

STATEMENT OF STEPHEN L. GOESER, ADMINISTRATOR/CHIEF EXECUTIVE OFFICER, MYRTUE MEMORIAL HOSPITAL, HARLAN, IA

Mr. GOESER. Thank you, Mr. Chairman. I am Steve Goeser, administrator of Myrtue Memorial Hospital in Harlan, IA. I also serve as chair-elect of the Association of Iowa Hospitals and Health Systems.

My organization is a 52-bed primary care county hospital in Harlan, IA. We serve one of the most Medicare-dependent counties in the State. My comments this morning focus on a number of specific rural issues that need to be addressed if this proposal or any Medicare reform proposal is to succeed in much of rural America.

If you will, consider this. Iowa leads the Nation in percent population over age 85, and we are third in percent population over 65. Two-thirds of Iowa hospitals depend on Medicare for more than 60 percent of their inpatient activity. As a group, Iowa hospitals have negative Medicare margins, and in 1999 fully 60 percent had negative patient margins.

Despite our heavy reliance on Medicare as a payer, only two States rank below Iowa in average program payments per enrollee. Iowans receive 30 percent less dollars per enrollee than the national average, and 100 percent less than the highest State. The bottom line is our providers are struggling with inadequate payments from their largest patient base and the beneficiaries do not have the same benefits and choices that their counterparts in other parts of the country have.

We believe that any Medicare reform plan should include three goals. First, the plan must be equitable for providers and beneficiaries, regardless of geographic location. Second, safety nets for rural and inner-city providers and beneficiaries must be in place to assure access to those at-risk populations. Third, real choices for rural Americans must be assured.

Any reform to the Medicare program must address the fundamental issues of fairness and equity. Today's Medicare program rewards Medicare beneficiaries and in some cases providers based on an accident of geographic location rather than any rational or equitable policy for distributing scarce resources.

As is the case with the Social Security program, all Americans pay the same Medicare payroll tax rate. But unlike Social Security, all Americans do not enjoy the same level of benefits under Medicare. Seniors that live in areas of higher AAPCCs receive more choices, as well as more benefits, as compared to lower AAPCC areas like rural Iowa, Nebraska, Wisconsin, and South Dakota. Tomorrow's Medicare program must restore fairness and equity to all Americans.

This particular legislation seeks to address the issue of regional variations in Medicare spending by adopting a geographic adjuster that will be applied to the Medicare premium contribution. The implementation of this adjustment is central to the future success of Medicare reform and the ability to provide real choices for rural Americans, as envisioned by the supporters of this initiative.

The legislation also seeks to protect beneficiaries in regions where no competition exists by offering HCFA-sponsored plans with beneficiary premium limits. This is a notable goal, but will unlikely be seen as positive by rural seniors who are aware of friends and relatives who have expanded benefits at little or no cost in other areas of the country.

As I understand it, this Medicare reform initiative is modeled as a competitive premium system similar to the Federal Employees Health Benefits Program. It is important to note that the variation in premiums for that program are no more than about 20 percent across the various regions of the country, a number significantly lower than the current AAPCCs used by Medicare to set HMO rates today.

The ability of the new Medicare Board to effectively tackle this disparity of rates will spell the success or failure of the legislative intent to bring Medicare choices to all Americans. Reform of the Medicare program to ensure fairness and equity, as well as program solvency, are daunting tasks, and I applaud you for your efforts.

Thank you for the opportunity to speak to you this morning on this important legislation and representing rural Iowa beneficiaries.

[The prepared statement of Mr. Goeser follows:]



Establishment of Competitive Medicare Premium System: A Rural Perspective

**Prepared Remarks for Senate
Special Committee on
Aging Hearing on First/Breaux
Medicare Reform Legislation
February 8, 2000**

Introduction

I'm Steve Goeser, Administrator/CEO at Myrtue Memorial Hospital in Harlan, Iowa. I also serve as Chair-Elect of the Association of Iowa Hospitals and Health Systems.

My organization is a 52-bed, primary care, county hospital that employs eleven practitioners. We serve one of the most Medicare dependent counties in the state of Iowa. My comments this morning focus on a number of specific rural issues that must be addressed if this proposal—or—any Medicare reform proposal is to succeed in much of rural America.

Iowa Perspective

Consider this:

- ✓ Iowa leads the nation in percent of population over the age of 85.
- ✓ Iowa ranks number two among the states in percent of population over the age of 75.
- ✓ Iowa ranks number three in percent of population over the age of 65.
- ✓ Twenty-six of Iowa's 120 community hospitals depend on Medicare for more than 80% of their patient days.
- ✓ Two-thirds of Iowa hospitals depend on Medicare for more than 60% of their inpatient activity.
- ✓ As a group, Iowa hospitals have *negative* Medicare margins.
- ✓ As a group, over 60% of rural Iowa hospitals had *negative* patient margins in 1999.
- ✓ Medicare is Iowa hospitals' worse payer.
- ✓ Only two states rank below Iowa in average Medicare program payments for Medicare enrollees.
- ✓ Iowa Medicare payments on behalf of beneficiaries are 30% lower than the national average and almost 100% less than payments for beneficiaries living in Louisiana.

The bottom line—Iowa is a state disproportionately affected by the Medicare program. Iowa providers are struggling today because of inadequate Medicare payments while Iowa beneficiaries today do *not* have Medicare choices that their counterparts have in other parts of the country. Some of those choices, available today in many areas of the country, include benefits not available in the basic, fee-for-service Medicare program.

Goals of Medicare Reform

Key goals that must be components of any Medicare reform plan include: (1) The plan must be equitable for providers and beneficiaries regardless of geographic location; (2) Meaningful "safety nets" for rural and inner-city providers and beneficiaries must be in place to insure access; and (3) Real choices for Medicare beneficiaries living in rural America must be apparent and assured.

Increasingly, the current Medicare program fails to adequately address these goals. Medicare reform must include the promise of meaningful change.

Medicare Reform

Any effort to reform the Medicare program must address the fundamental issues of fairness and equity. As is the case with the Social Security program, all Americans pay the same Medicare payroll tax. But unlike Social Security, all Americans do not enjoy equal health care benefits under Medicare. Medicare has different payment rates for the same service based on geographic location and Medicare utilization rates vary significantly across the country. The result is a highly complex program that penalizes efficient health care providers and disadvantages beneficiaries in many rural states. Inadequate provider payment levels and an absence of beneficiary health plan choice threaten the delivery of quality health care services for seniors in our state. This problem also exists in other rural areas of the country, especially upper Midwestern states like Nebraska, Wisconsin and South Dakota.

It's important to mention that noted health care expert Dr. John Wennberg, Director of the Center for Evaluative Clinical Sciences at the Dartmouth Medicare School, attributes most of this payment variation to utilization issues, not cost of business differences in the various health care markets. Today's Medicare program rewards Medicare beneficiaries and, in some cases providers, based on an accident of geographic location rather than on any rational and equitable policy for distributing scarce resources. Tomorrow's Medicare program must restore fairness and equity to the equation for all Americans.

Medicare reform proposals will succeed or fail in rural America based on their ability to effectively address this fundamental issue. This particular legislation seeks to address the issue of regional variation in Medicare spending by adopting a "geographic" adjuster that will be applied to the Medicare premium contribution. The implementation of this adjustment is central to the future success of Medicare reform in traditionally low cost/low utilization areas of the country. The government's contribution will need to reflect a blend of local and national costs to provide an adequate premium to assure choices for beneficiaries. The inability of the current Medicare HMO payment to adequately blend national and local costs dooms rural seniors to reside in markets that are absent the choices envisioned by supporters of this initiative.

The legislation also seeks to protect beneficiaries in regions where no competition exists by offering HCFA-sponsored plans that include beneficiary premium limits. This is a notable goal but will not likely be viewed as a positive alternative for beneficiaries who are aware of friends and relatives who have access to low or no cost choices in other areas of the county.

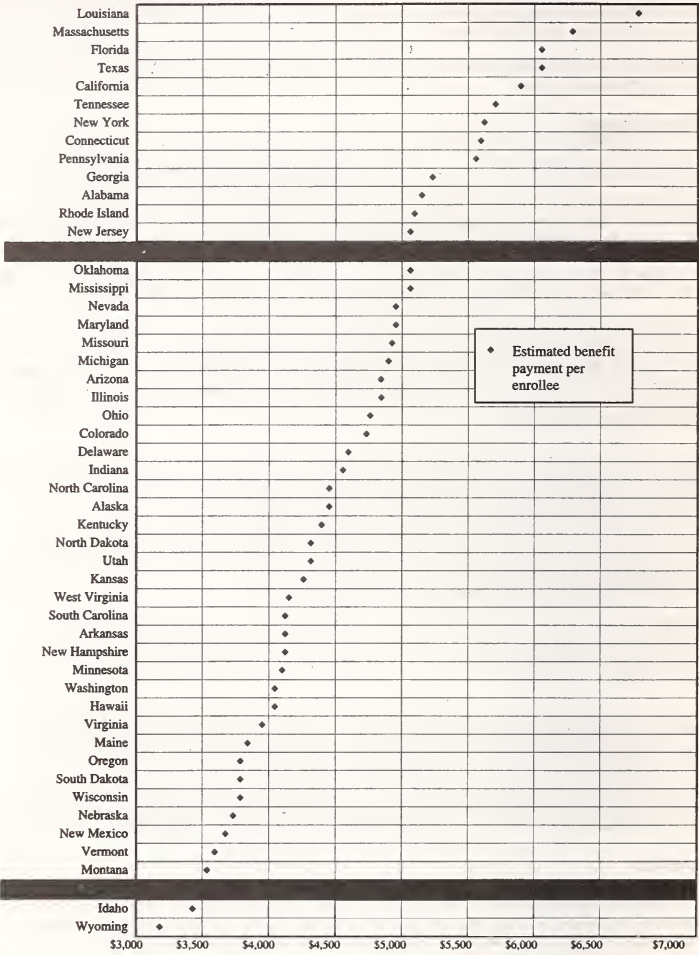
A stated goal of this Medicare reform initiative is to model a Medicare competitive premium system after the Federal Employees Health Benefits Program (FEHBP). Importantly, regional variations in premiums for that program amount to no more than 20%, a number that is significantly lower than Medicare's current AAPCC payment variations which can differ by as much as 100%. While the FEHBP goal is laudable, the history of legislative and regulatory inertia on the topic makes me a bit skeptical as to whether or not the new Medicare Board will be able to overcome the politics of the issue and effectively tackle this problem. Hence, it's important that legislative intent clearly embrace the goal of fairness and equity as a priority that must be addressed by the Board.

Conclusion

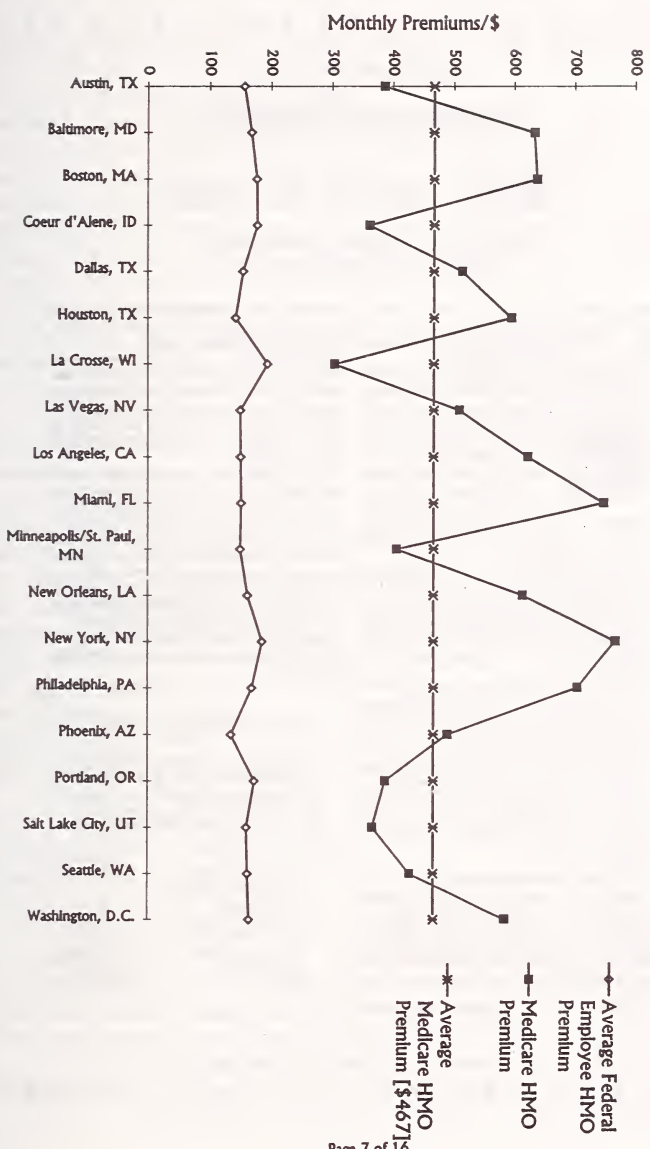
Finally, a recent Des Moines Register editorial included a headline stating that *Medicare Cheats Iowans* and notes that presidential candidates trekking through our state have uniformly ignored the issue. I'd like to see greater emphasis on correcting the inequity as part of this or any other Medicare reform measure.

Attachments: State-by-State Payment Chart
FEHBP Graph
Editorial

Medicare Program Payments per Enrollee By State of Residence



Comparing the Variation. 1997 Medicare and Federal Employee HMO Premiums



Des Moines Register-January 5, 2000

THE REGISTER'S EDITORIALS

Now, here's an issue

■ How come Medicare is more generous
in candidates' states than in Iowa?

Presidential candidates wanting to score points with Iowa on the eve of the caucuses could manage that with a single promise: simple justice in Medicare.

Candidates soar to oratorical and obfuscatory heights when talking about their health platforms. The generalities come easy. Forget them. Let's get very, very specific: Medicare cheats Iowa doctors, Iowa nurses, Iowa hospitals and Iowa's elderly citizens — big time.

Meanwhile, Iowa wage earners are forced to subsidize the Medicare programs in the home states of every single presidential candidate.

In George W. Bush's Texas, for instance, a person eligible for Medicare is likely to be wooed by HMOs offering coverage for prescription drugs, dentistry, glasses and hearing aids, none of which are covered under Iowa Medicare. In Iowa, you pay for those yourself; Medicare won't.

Hey, Medicare is a federal program. Why is there a difference among states? Because in the past, Iowa doctors and hospitals tried responsibly to provide excellent health care at reasonable costs. Medicare's reimbursement rates are fixed on the basis of average benefit payment per enrollee, which for elderly Iowans now averages \$3,456 yearly. In Texas, it's \$6,016. At that price, an HMO can offer Texans all the extra goodies and still show a handsome profit.

Iowa?

HMOs don't even bother to ask.

Meanwhile, Iowans pay exactly the same Medicare tax on a dollar earned in Iowa as a Texan pays on a dollar earned there. But you don't get anywhere near the same benefits. Rural Iowa hospitals and providers have the lowest reimbursement rates and are hurt the worst.

As an Iowan, you are penalized for the thrift

of our doctors and hospitals. Other states are rewarded for piling on the costs, and your Medicare taxes subsidize them.

Texas isn't alone. Iowa gets lower reimbursements than every state except Idaho and Wyoming, whose reimbursement rates are somewhat lower than ours. That's despite the fact that Iowa has the highest percentage of citizens in the age category where medical needs are greatest.

The candidates like to talk about broad-based health-care reform involving universal insurance, expanded Medicare coverage, etc. — important issues. But don't talk expansion of Medicare coverage to an Iowan if it means care will be distributed under the same unconscionable and indefensible formula that has cheated Iowa for years. We don't want to hear about it, sir, until the ridiculous disparity by which your state cheats ours is erased.

Presidential candidates unfamiliar with how wide the disparity is are invited to check the attached list.

Iowa Medicare blues

Following are Medicare reimbursement rates per enrollee, by state. Medicare programs in at least five of these states offer the elderly options such as drugs and eyeglasses that Iowa cannot.

Texas (Bush)	\$6,015
Tennessee (Gore)	\$5,728
New Jersey (Bradley, Forbes)	\$5,061
Maryland (Keyes)	\$4,930
Arizona (McCain)	\$4,804
Kentucky (Bauer)	\$4,383
Utah (Hatch)	\$4,247
IOWA	\$3,456

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The CHAIRMAN. We will now have 5 minutes for each member, and I would like to suggest that we probably can only have one round of questioning per panel. I will go first, and then Senators Breaux, Wyden, Bunning, Collins, Bayh, Lincoln, Jeffords, and Reed, in the order of their arrival.

I hope I can get in four questions before my time is up. I am going to ask my Mr. Goeser, to respond but would you listen, Dr. Wilensky, and see if you could comment on it as well?

You mention in your testimony that the variation in payments to providers is much smaller in the Federal Employees Health Benefit Program. Can you and Dr. Wilensky comment on why that is and on whether the same approach could work for Medicare?

Mr. Goeser, would you start out?

Mr. GOESER. My understanding is that the FEHB program is probably more in tune with the actual costs of providing care to that population, where in Medicare we have fixed costs at a certain point in time and then have updated payment percentages, market basket minus, usually. So if you are on the low end of a cost to begin with and you get a 2-percent increase across the board, the 2 percent on the low end isn't as much as the 2 percent on the high end. So it just widens the gap as you go through time.

The CHAIRMAN. Can it work for Medicare?

Ms. WILENSKY. Well, let me explain why we have the wide variations, and it is basically because of what goes on in traditional Medicare. Traditional Medicare is not viewed within a premium context. We have ways to try to moderate spending, but if you think about what is spent under Medicare per person covered, it varies extremely widely, before 1997, from \$225 per senior per month in some areas of Nebraska, to \$780 per senior per month in some places in South Florida, New York, and Southern California.

What you passed in 1997 was to try to narrow the range and to put a floor, first, of \$370, roughly. It is now about \$410 per senior per month, but there is still a tremendous variation at the upper end. Again, I would like to point out it happens because of what goes on in traditional Medicare, which is very different practice styles, sometimes differences in health status and cost of living, and probably differences in demand from the seniors as well. And there is no attempt made to try to narrow those differences.

When you have premium-oriented plans such as the FEHB program, it becomes much more obvious what those differences are, and it forces you to face the premiums that are reflecting both use and price in a way that is easy to ignore under traditional Medicare.

Whether or not the Congress would choose to try to force more consistency by looking at best practices or conservative practice styles is something the Congress will need to think about. You could do that, but expect to have a lot of complaints in the areas where you have been used to having very aggressive practice styles.

In the list that Mr. Goeser read off, he did not mention one of the ones, which is the State of Oregon, which has frequently been an example of a very conservative practice style State which also

is hurt by the fact that we don't try to narrow down this range. You could, but it will be politically difficult to do so.

The CHAIRMAN. Mr. Goeser, in your State association that you chair, do you see this break in the historical link between the area premium payments and the Medicare expenditures as being something that is beneficial under the Breaux-Frist bill to rural America?

Mr. GOESER. Well, it appears that that is the intent, that the premium support and standard benefit plan would bring up rural areas. But my concern really, Senator, is that we are dealing with two important issues here. One is beneficiary benefits and premium costs, and two is provider payments. To me, the bill is silent on what would happen with provider payments under this plan. If we continue to pay under the current system and lose access for seniors, the premium support will really have no benefit.

The CHAIRMAN. Mr. Walker, you stated that substantive financing and programmatic reform are necessary to put Medicare on a sustainable footing for the future. You have also cautioned Congress to couple any new prescription drug benefit with Medicare reform.

If we add an outpatient prescription drug benefit without making any structural changes to the program, what will this do to the financial picture of Medicare?

Mr. WALKER. Mr. Chairman, it would depend upon what the financing sources are, in other words how you plan to finance those additional benefits. I know, for example, Senators Snowe and Wyden are proposing to tap some tobacco taxes and other sources as a means to hopefully make sure that it pays for itself. Whether it will or not, I think can be debated.

Mr. Chairman, I think what is very important is there is no question that the benefit structure needs to be updated, and I think there is a broad consensus that something needs to be done with prescription drugs. At the same time, our concern is if you end up doing the most positive thing first, then this takes away some of the incentive of doing some of the heavier lifting. And the heavier lifting needs to get done. We also need to be able to deliver on the promises we have already made.

The CHAIRMAN. Dr. Wilensky, the question I asked Mr. Goeser—I thought afterwards that you wanted to comment on it and I didn't call on you. Would you do that now?

Ms. WILENSKY. I think that with regard to the payment to providers, one of the advantages of the Breaux-Frist bill is that it will allow other health care plans to come in perhaps as they do for FEHB, where they serve some rural areas and not specify what the payments should be.

What I have been told in inquiring as to how they can provide benefits to rural areas, they have indicated that sometimes when they do their weighted-average bid they actually allow for slightly higher reimbursements to rural areas because you don't have the effects of competition lowering the prices that you have in urban areas.

So I would be very hopeful that if you didn't have all of the micromanagement regulatory structure that HCFA has put in place for Medicare+Choice plans, you could have more choices and

at the very least you have guaranteed that people have traditional Medicare available to them with some caps on the premiums. So I am actually much more hopeful that rural areas would fare better than Mr. Goeser has feared.

The CHAIRMAN. Senator Breaux.

Senator BREAUX. Well, I thank the panel very much. Let me just ask—and I guess, David Walker, you could respond first on this. I mean, Congress this year is going to have this great choice to make and it is going to really be interesting to see how we come down on this.

One of the choices is do we add prescription drugs to Medicare. I mean, please raise your hand if you are not for doing that and you will promptly be run out of Congress. I mean, everybody is for it. The need for it has been clearly proven. We should do it.

The question is we have a program that we are adding prescription drugs to that this year has a \$7 billion deficit, \$7 billion, that is projected to become insolvent in the year 2014. So my question is a general question. Suppose we just do the easy thing by adding a new program to Medicare and don't address the structural reform that has brought us where we are. Can you talk about the consequences of doing that?

Mr. WALKER. Well, first, it is always easier to deal with the things that everybody wants and that are additive than it is to deal with the fundamental structural imbalance in the program, the financing imbalance. Obviously, unless any incremental benefit is at least paid for, then you are going to exacerbate the financing problem that we already have with Medicare which is very, very significant, is going to grow very rapidly, and is far in excess of Social Security.

Our concern, Senator, is that if you don't end up coupling real reform with the enhanced benefit, you may not get around to the real reform for a while.

The CHAIRMAN. The administration's drug program, I take it, is about \$195 billion over 10 years. And they would argue that, well, it is paid for, we are going to use the surplus to pay for it, we are just going to put more general revenues into the Medicare program. Is that a sufficient answer?

Mr. WALKER. Well, general revenues may well be part of the answer that the Congress decides to deal with, and I think one could reasonably say that given the size of the financing imbalance in Medicare, revenues may well play a part in how you are going to close that gap.

At the same point in time, general revenue financing would represent a fundamental change for Part A as compared to where it has been in the past. And as you know, in your proposal you have to have some kind of limit. Where do you draw the line? Right now, we have the Trust Fund balance. You are proposing the 40-percent limit of general revenues, which we project will be hit about the year 2008. Then the practical question is what do you do when you hit that limit? What gives? That is where the proverbial rubber meets the road.

The CHAIRMAN. Well, I thank you for it. I am for adding prescription drugs, I am for putting more money into the program as well,

and I am also for structurally reforming. I think the three need to go together.

Let me ask the question, suppose—here is the thing that I am really wrestling with—suppose we can't do the complete reform package that is envisioned in the Breaux-Frist bill. Yet, we do want to do something on prescription drugs because of all the reasons we all know. What could we possibly do that would move us toward reform and prescription drug coverage.

Gail, can you maybe address that?

Ms. WILENSKY. I would very much encourage you to think this way. If you can't, I most would like you to do the overall reform with prescription drugs. I would like to see you think about starting with the lowest-income individuals who are just above Medicaid. That is the group that is disproportionately Medicare-only, and therefore for sure don't have any drug coverage. And there are a couple of different ways.

You have already identified the so-called QMB-SLMB populations for special health, the qualified Medicare beneficiary and the specified low-income. You could just say those that we have already designated to get premium and deductible co-insurance or some combination support from the Government ought to be covered with a package of benefits until we can get it together to do all of Medicare reform.

There are a couple of other spins. You could do something like the CHIP program where you give money to States and they could develop their own program, or you could give money to States and let them build the pharmacy assistance programs. It would be something clearly indicating a temporary measure to cover the lowest-income.

Senator BREAUX. OK, that is on the drug program. Now, what kind of reform do I get for that? I mean, what do I need from your perspective in terms of reforming structurally the Medicare delivery system in order to make some movement on the prescription drug side?

I can't get the comprehensive thing done. What ingredients would be compatible with moving gradually in that direction, if anything?

Ms. WILENSKY. Set up a Medicare Board. I mean, one of the things that you have just got to do is take HCFA, which has a fundamental conflict of interest—their focus is on traditional Medicare, their expertise is on traditional Medicare. Somebody else needs to be running the other Medicare replacement programs. Start with that. You will have a lot of issues to wrestle with about how much authority, who appoints them, how long. I know that has been answered in the bipartisan report, whether or not those are the answers the Congress would want to have. I think that would really start the institutional structure-building that you need.

Senator BREAUX. That is a very good point. If you could continue to help us with that thinking, I would be very appreciative.

Mr. Goeser, thank you very much for your presentation. I really understand and appreciate what is happening in the rural hospitals, but we are continuing. I mean, the President's budget in order to try and make this whole thing work is looking at \$4.3 bil-

lion over the next 5 years in additional hospital cuts over what we have already done, and reducing the hospital update by .8 percent for urbans and .4 percent for rurals. That is in addition to what you have already got.

Now, I will say this. The administration, I think, is trying very desperately to make this program work. They are trying to add drugs and balance the budget and get enough money to run the program. And I think they are for reforming the program, and I think that hopefully we can work together to do what they want to do and what we are trying to do in bringing about a better delivery system for you and the 40 million Americans out there.

Thank you all very much. You have been very helpful.

The CHAIRMAN. Senator Wyden.

Senator WYDEN. Thank you, Mr. Chairman.

Mr. Walker, as you know, 10 days ago I told you I would ask you about what the bill Senator Snowe and I have introduced. And you talk about heavy lifting. I have spent a big chunk of my waking hours these last 3 months and got a real sore back from the heavy lifting in this bill. Let me outline for you what the heavy lifting is.

The fact of the matter is we use competitive principles, private marketplace forces, as the delivery system. Second, we have got an ability to pay feature, a dramatic transformation in the Medicare program. Third, we don't put HCFA in the driver's seat because we know that that is a non-starter with many of our colleagues. Fourth, we went out and got 54 United States Senators to actually vote to put hard dollars into the program. That is heavy lifting by my way of thinking.

I think the only thing that I am concerned about is that everybody on that side of the dais has got prescription drug coverage if they want it. Everybody up here has got prescription drug coverage if they want it. I heard from an elderly widow in Yoncalla, OR, a couple of days ago. She has got \$150 a month left to live on when she is done paying for her prescription drugs. She is like Senator Lincoln's constituents—no pharmacy, no hospital anywhere close. We have got to make sure that there is something for her.

My question to you is if you have key competitive, reform-oriented principles like the four or five that I have outlined and it is adequately funded, what are your concerns about trying to move forward based on those kinds of principles which, as I understand it, is what GAO has been calling for for years?

Mr. WALKER. First, Senator, let me acknowledge that your proposal is intended to be targeted, it is intended to be self-financing, and I think those aspects are positive. There is no question about that. I think really what you come down to, Senator—and obviously you get elected and the other members get elected to make these choices, not us—is while there is no question that prescription drugs at some point in time are going to be added and there is no question that having marketplace principles and having a targeting mechanism is the way to go, I think the thing that is going to have to be debated is it best to go ahead and do that first, because politically obviously it would be easier to move on that than it would be more comprehensive reform.

Then the question you have to ask yourself is if you take that approach, then does that relieve pressure and what is the likely

impact going to be on the heavier lifting. I realize anything in Medicare, Senator, is heavy lifting; anything is. But the relative heavier lifting, which is being able to close the gap based on current promises, and there is a huge gap there, is really the issue.

Senator WYDEN. Well, let me ask you then this because what you have said is substantively you don't see flaws in Snowe-Wyden. What you are saying is the politics are such that you know, you better not do prescriptions now because you won't be able to come back.

My response to you is every single one of those four key principles that I outlined—competition, ability to pay, keeping HCFA out of the driver's seat, and getting the votes for adequate funding—is what you have to do long-term as well. You are going to have to do that long-term and short-term, and my question to you would be why not have GAO, for example, take a look now.

Say we go with something along the lines of what Senator Breaux and Senator Frist and Senator Snowe and I are talking about, and the administration, based on those kind of four principles. Why wouldn't you guys take a look at a kind of trigger mechanism which would give us some recommendations on how to go forward after that? Would that be something you all might be receptive to?

Mr. WALKER. We would be happy to work with you and the committee on looking at various options. I think ultimately, whatever trigger you have—right now, we have a trigger called the Trust Fund solvency, and that is all it is. It is a trigger, it is a signal, if you will. Ultimately, whatever trigger you have, the question is going to be what is going to happen when you hit that trigger, you are going to hit it, you are going to hit it. It is only a matter of when you are going to hit based upon projections in health care costs.

Senator WYDEN. The other area I would like you to take a look at—and the Congressional Budget Office has begun some work on this as well—is we need better information on utilization issues. It is very clear that it is possible at the outset to make some judgments about what utilization rates are going to be, but down the road we don't know a whole lot about some of those issues. Have you all done any work in that area?

Mr. WALKER. I would have to check; not in terms of projections. We have done some historical things, Senator, but we haven't done projection work. But you are correct that it is really intensity, which is driven by technology. Utilization, as well as inflation, is really what is driving these costs, as well as the demographic trends.

Senator WYDEN. My time is up, but I want it understood that what I have taken from your testimony based on the four kind of principles that we think are awfully heavy lifting—you are going to have to do it for prescription drugs, you are going to have to do it for everything else. The biggest concern you have is that it is politically hard to go forward with other reform efforts if you do prescription drugs.

Frankly, that is something that we have tried to think a lot about, and I want it understood we are not trying to gorge on desert here. This is going to be very, very hard work, and I look for-

ward to working with you particularly on a trigger concept and on some utilization issues.

Thank you, Mr. Chairman.

The CHAIRMAN. Now, we have Senators Bayh, Lincoln, Jeffords, and Reed.

Senator BAYH. Thank you, Mr. Chairman.

Mr. Walker, my first question is to you, getting back to the first chart that you put up in the beginning of your comments. It seems to me we need a greater sense of urgency about this issue, not only for those who care about Medicare and preserving the solvency of Medicare and for those who would like to see it systemically improved by adding a drug benefit to ease the burdens too many of our seniors face, but for all the other issues that the Federal Government is involved with.

It seems to me the import of your first comments run something along the following lines that if you care about education investments, you need to care about this issue. If you care about infrastructure investments or research or mental health or other areas that we have to address as a society, you need to care about this issue because before very long the consequences of inaction will be there will be no funding left for any of those other areas. And, in addition, Medicare itself will be headed down the path to insolvency.

Was that the import of your opening comment?

Mr. WALKER. Senator, you are exactly correct. The fact is you just can't look at Medicare standing alone. You have to look at the ripple effect. And to the list that you just gave children's programs and national defense, believe it or not, is deemed to be discretionary spending. So you are correct. There is a broader debate here and we need to get on with it.

Senator BAYH. We really need to inform the American people about the urgency of this topic because Medicare itself is one of the top concerns as a Nation we have, but this indirectly is going to affect everything else we do. And the sooner we get that word out and a greater sense of urgency we can create, I think the better off we will be.

It has been my initial impression that it is hard for this institution to take difficult steps even when times are tough and we are facing the consequences squarely, let alone when times are good, as they are now. But we have to look just beyond the horizon and see how tough they are going to be and we need to act now and create that sense of urgency, which leads me to my second question to both Ms. Wilensky and to you.

I take that we have not yet repealed the law of economic cycles or the fluctuation of economies, although times have been very good now for a historic period of time. Tell me just briefly if you could share with us what the consequences of even a mild downturn in the economy, mild by historic standards, would be on the solvency of Medicare.

Ms. WILENSKY. Well, first, as I mentioned, the movement reported by the trustees last May from 2010 to 2015 was based on very, very thin surpluses in the first 5 years of this decade. Any disruption, any slowdown in economic growth and employment or

any increase in hospital spending or other Part A spending, skilled nursing facilities or home care, would disrupt that balance.

We would find ourselves, instead of thinking of 2015, thinking of 2011, 2012, 2013, and these are just very mild bumps in the road. You can hardly see the surplus, it is so narrow. If we were to have a significant downturn, that obviously would not only affect the outyear projections, it would also affect the immediate ones.

Let me add, if I might, Senator Bayh, that it is not just seniors who have to understand the implications of Medicare and future Medicare spending. The real problem is that the baby-boomers and the baby-bust generation that came after them don't seem to look at issues of Medicare as their problem, although they should because they will be paying for all of the time. And what is there when they get to be 65 or whatever age we deem is appropriate is as much their problem as the existing senior problem. They don't think about it at all.

Mr. WALKER. Senator, on that I think I would suggest that you look at the most recent CBO projections. They had a number of different projections, and if you assume that discretionary spending goes back to historical patterns, including emergency spending, if you add a 1-percent incremental cost to projected health care costs, which is clearly possible, you go from surpluses to deficits. So, that shows you the volatility that we are dealing with here.

Senator BAYH. So relatively minor adjustments on either the spending side or the inflow side could have a substantial impact on the solvency of the system?

Mr. WALKER. Correct, and the broader budget picture as well because of the impact of compounding. And, last, the intergenerational issue is a very real issue here because you are making choices not just for today. The choices you make today will have very profound implications on the type of life your children, and I know you have a number, will live and their children will live, and how much flexibility they have to make some of their own choices about how resources ought to be allocated rather than having all those choices made several decades ahead for them.

Senator BAYH. Thank you, Mr. Walker. Just one brief editorial comment, then one final question, Ms. Wilensky, for you. I was just dumbfounded by the figure that I think Senator Frist put out about 100,000 pages of regulations.

Senator BREAU. 133,000.

Senator BAYH. 133,000. It strikes me as improbable that a system with 133,000 pages of regulations is going to provide either efficient or compassionate, quality care. That is why injecting some competition, some choice into the system, I think, will not only make it more efficient, but in the long run make it a higher-quality system as well.

Just briefly, Ms. Wilensky, I am still learning the language around this place. You mentioned something called risk adjustment payments. Under the current system, they, I guess, implicitly exist, but under some of the proposals they would explicitly exist. Can you just briefly tell us what they are and why they exist under the current system and what the impact on the future system as proposed under the Breau-Frist proposal would be?

Ms. WILENSKY. The concern has been all along that by paying an average payment, adjusted for the age and sex of the individual, to an HMO, if there were healthier than average people choosing HMOs on the grounds that they didn't have the ties with some of the existing community physicians, you would actually spend more than you would have.

You also encourage bad behavior. If you have very sick people who want to join a managed care plan, but know that the plan is not going to get any more money, neither the individual nor the plan has much reason to try to have that type of individual join them.

As part of the 1997 Balanced Budget Act, Congress directed HCFA to make adjustments to the payments to reflect the health status of the people who are there. It was to begin in early 2000 and over a 5-year phase-in to make those adjustments. The Congress has slowed down the adjustment process, delayed it and slowed it down, because the concern has been that the information that was available was only based on hospital admissions in the previous year.

What it meant is that if you had a plan that engaged in disease management, kept people with congestive heart failure out of the hospitals and emergency room, they would basically get hit twice and, in fact, may still have that problem. It costs a little more to run some of these preventive health care plans, and if they prevent hospitalizations, they actually will get less of an adjustment than they would have.

The specifics about how you go about using good data reflecting health care status rather than only utilization is a thorny issue. But making the adjustments is very important because otherwise you will either reward plans that, by luck or by intent, have healthier people and penalize plans that try to do the right thing and get cancer experts and hypertensive experts, and you will hurt them financially. So we need to resolve it, but we need to resolve that issue now with Medicare+Choice as an option, and it is not just a Federal employees health care model problem.

Senator BAYH. So in a nutshell, this equalizes for distortions that result as a result of the selection process?

Ms. WILENSKY. The selection process or just bad luck in terms of who ends up where.

Senator BAYH. Thank you.

Ms. WILENSKY. You are welcome.

Senator Breaux [presiding]. Senator Lincoln.

Senator LINCOLN. Thank you. Mr. Walker, you made it clear in your testimony and we have talked here in some discussion that Congress should be cautious about not committing too to many Federal benefits at this point and what kind of ramifications that might have, especially in view of the unpredictability maybe of the surplus.

In your testimony, you suggest that Congress should consider adequate fiscal incentives to control costs, and you use a term called "targeting strategy." I would like to give you an opportunity to kind of elaborate on what you mean by targeting strategy.

Mr. WALKER. Part of that, Senator, is for whatever benefits you have, to the extent that there is going to be a Federal subsidy,

there would be greater support for those most in need, whether it be prescription drugs or otherwise, and a need to also create more transparency to the beneficiary about the cost of health care.

By taking a marketplace approach where, for example, you have choice, where people have choices of the different types of benefit packages they may choose from, then they have more choice. And, second, you could target the subsidies toward those most in need, whether it be prescription drugs or anything else. People that were better off would pay more.

Senator LINCOLN. What about rural States where maybe you have less of that? We have got more fee-for-service, obviously, in Arkansas, with less managed care.

Mr. WALKER. Senator, I think one of the things that we are doing work on as a result of the BBA, the last Act dealing in this area, is we are doing some work on the very real issues associated with the special challenges associated with rural areas. That is one of the equity issues that you must take a look at, and I think there are very real challenges there that have not been focused on adequately and we have got some work ongoing right now that we hope will help the Congress.

Senator LINCOLN. I just hope we don't miss that point and making sure that we are focusing on it.

Dr. Wilensky, welcome to the committee. I remember working with you from my days in the House, and appreciate your input here today. You talk about a temporary prescription drug benefit and I am curious to know what you are talking about or maybe just to elaborate a little bit more about how this block grant to the States would work that you are mentioning.

Ms. WILENSKY. With regard to the question that you just asked David Walker about rural, as part of the charge of the BBA Refinement Act, you have asked MedPAC to respond to a number of rural issues. And in our June of 2001 report, we will be entirely focused on rural issues to respond to the various issues. So it is a ways to wait, but hopefully it will address a number of the rural issues that the committee has raised.

I would prefer to have a full prescription drug benefit, let me be clear. And I appreciate the efforts that Senators Wyden and Snowe have gone to to have a fiscally responsible stand-alone bill, although I very much share David Walker's concerns about doing a full prescription drug benefit first, of how long it will take to do the next round.

That is really what has put me into thinking about on a temporary basis helping out the lowest-income seniors who don't have prescription drugs. And it seems that there really are a couple of models that we already have in place, so we don't need to introduce something that is hard to think about.

The first is the CHIP program, the Children's Health Insurance Program, where money goes to the States. The States can either expand Medicaid or do something else. The "doing something else" seems to be taking HCFA a long time. So that is the cautionary note, but we have a mechanism in place and it is up and running.

The second thought that I had has to do with State pharmacy assistance benefits. Fourteen to sixteen States now have pharmacy assistance benefit programs. Two or three States are thinking

about it, again, purely temporary. It usually is focused on people below the poverty line or 150 percent of the poverty line. They work differently in different States. The idea is to fund that, again, to try to hit something fast.

What perhaps is the easiest way, although there are a lot of administrative issues which exist in all of the bills in terms of what we really mean by private entities or PBMs to run them, would be to target the classes that Congress has targeted in the past, the so-called QMB and SLMB, those groups that either have their Medicare premium deductible and co-insurance paid for or only the premium paid for already by Government, and to say this group we have already identified for special help. On a temporary basis, we will put in a prescription drug benefit for them, learn what we think we mean by all these concepts of PBMs and private entities, and just start there. But by far, my preferred way is to do the whole thing.

Senator LINCOLN. You are talking about pilot projects, almost, within a certain group or category of individuals.

Ms. WILENSKY. But target the people who really we can't say wait until we get it together to do the rest.

Senator LINCOLN. Right. Well, I would just comment on that in terms of the bill that I have introduced here on the Senate side for the CHIP program. We have had some difficulty in getting participation and implementation in the States on that program, and hopefully if we do look at something like that, we will recognize and learn from our shortcomings in that.

I would also like to just make a comment on your comment from the last question about the baby-boomer generation and the importance of it to them in the years to come.

I would just say that it is not only for us as baby-boomers but the fact is that we are the sandwich generation, too. And it is not just our own benefits, but if our parents' benefits run out, who is going to be left holding the bag? I know I have two sisters and a brother and the four of us would be sharing that responsibility for our parents' prescription drugs, which is not small now, but 11 years from now it is going to be incredible. So I would say that it is not just our own benefits that we need to worry about as baby-boomers, but it is our responsibility to our parents currently and in the next 10 to 11 years.

Mr. Goeser, I just wanted to compliment you. I obviously mentioned in my opening remarks the importance to me and to our State in Arkansas on behalf of the rural issues. I am pleased that you are here and your perspective is being presented. I share your concerns and have been fighting since my days in the House to be able to recognize and try and impress upon my colleagues and others that regardless of what people think in our Medicare and Medicaid systems that the cost of doing business in rural areas—they have always thought it was less than it was in urban areas and it absolutely is not. And I can attest to that with many, many stories.

So I am looking forward to working with my colleagues and appreciate your comments, and if you have got any one particular area where you think it is probably most prevalent where we need to focus in terms of rural areas and to make sure there is some-

thing we are not talking about or we haven't mentioned that you think is going to be most important, I would be appreciative of hearing what you think the most important thing for those rural areas would be.

Mr. GOESER. Well, I really believe that most of our rural areas are going to be left with one plan, the HCFA standard plan. And if we continue to pay that under the current system, they won't be able to survive. A Lewin report came out less than 10 days ago, and for Iowa it shows that even after BBRA, our Medicare margins are going to be at minus 16 percent by 2005. That can't be allowed to continue.

Senator LINCOLN. Thank you. Thank you, Mr. Chairman.

Senator BREAU. Senator Jeffords.

Senator JEFFORDS. Mr. Goeser, in your testimony you point out the disparity of Medicare payments to Iowa providers. Vermont providers face the same problem, as you know; they are fifth from the bottom in the chart in your testimony. To my mind, these huge disparities have a negative effect on the ability of elders living in Iowa and Vermont to get needed health care.

Can you give examples of how this disparity in Medicare payments affects the quality and type of health care that seniors and disabled people get?

Mr. GOESER. Well, I am not familiar with other States, but we are quite fortunate in Iowa that most of our community hospitals have been subsidizing the Medicare shortfalls to ensure access to seniors for their needed care. Currently, we are running cardiac rehabilitation programs and respiratory rehabilitation programs, and the Medicare payment cannot cover the cost of doing that. But because we are tax-supported or community-supported through donations, we are able to keep those types of services because they are genuinely needed and those seniors have to have access to it.

The concern obviously is that as those margins get worse and worse, we are seeing our margins dwindle. All community hospitals have a limit as to what type of charitable contributions they can tap or tax-support. Those will run out and then the safety net is gone. Obviously, seniors in Iowa that have no HMO options do not get prescription eyeglass coverage. They do not have pharmacy benefits. They don't have some of the more rich benefits that you see in some of the higher-cost areas.

Senator JEFFORDS. Thank you.

Mr. Walker, can you enlighten me on how projections are made, basically? I know we are looking at possibly going into a deficit situation with respect to Medicare. When I looked at estimates for life expectancies, which have a huge impact upon projections, I found great dispositions the Social Security projections, nobody is going to live any longer, and, therefore, you see a flat line resulting in huge surpluses. On the other hand, I asked the Census from their projections which make it seem everybody is going to live forever.

Who makes the decision on how to choose those projections, so that we know whether we are getting a figure that is realistic or that just helps the budget?

Mr. WALKER. Senator, the Social Security and Medicare Board of Trustees ultimately has the responsibility for coming up with these assumptions. And as you probably know, I was on that board for

5 years, from 1990 to 1995. They come up with a high-cost estimate, a low-cost estimate, and a best estimate. These projections are based upon the best estimate.

The three areas where there is probably the greatest dispute as to what the right assumption is, because when you are projecting out 75 years, Lord knows what it is really going to be—you are making an educated guess—are life expectancy, as you properly point out; productivity; and then what they call the health care cost trend rate, what is really going to happen with health care costs long term, not just considering inflation, but utilization, intensity, and a number of other factors. And so it is the Medicare Board of Trustees, Senator.

Senator JEFFORDS. Thank you. Let me go on. Your testimony dovetailed with my concern that the current Medicare+Choice program allows in some enrollees in higher paid premium locations to receive benefits such as prescription drugs, while enrollees in States that have less expensive health care, like Vermont, don't even have reasonable access to managed care benefits.

Can you elaborate on how a modernization plan might be structured to ensure greater geographic equity among the enrollees?

Mr. WALKER. This is one of the areas we are doing work on, Senator. I mean, there is no question, as has been noted in this hearing, that right now you have a situation where rural areas to a great extent are covered by the standard fee-for-service package and as a result they don't have as much choice.

In addition to that, if you look at the way that that program is currently managed for reimbursement purposes, there are some other challenges associated with whether or not those amounts are adequate. So these are examples of areas that we are doing some more work on as a result of BBA in order to try to shed some more light, and we would be happy to provide that to Congress when it is done.

Senator JEFFORDS. I appreciate that.

Ms. Wilensky, I was interested in your comments about the incremental prescription Medicare benefits. I also point out to my colleagues that I have introduced three bills which range from comprehensive drug benefits through reform of Medigap, to measures strictly targeting needy elders through State-based programs.

My question has to do with benefit equity. How can we modernize the Medicare program so that all beneficiaries have access to the enriched benefits which today's health care system demands?

Ms. WILENSKY. I think a good way is through the premium support world such as Breaux-Frist, where you attempt to look at premiums in a more global way. As I understand it, what they have proposed is looking at the national weighted average of what is being offered in terms of what is being bid. You assume current individual versus government payment rates, 12 percent as a starting point, and you reward people who choose less expensive plans by paying more of the premium. And if they pay above the average, basically, they pay the full freight and somewhere in between.

It is just incredibly unfair what goes on now that the monies that are collected through a wage tax and an income tax, since part of it is income, goes out to some States in much greater amounts per senior than in other States based a little on their cost of living,

which is fair. And there are also some health status differences, at least at the county level, but a lot of it just reflects very different practice styles that some areas engage in and very different demands by patients, and it has resulted in very unfair distributions of money.

Looking at these Federal premium support type models would, if structured properly, equalize that benefit, but it will cause some discomfort, if it happens, in the areas that have been very aggressive. I mean, they have had a lot of money going to them. They have physicians and other provider groups that either they are being much more aggressive and/or the patients that see them are much more aggressive in terms of what they demand.

And as what happened with the relative value scale, when you attempt to do some equalization in order to bring the people haven't been getting very much up, you are going to take it out of the hides of the others and they will complain. But I have great sympathy for the rural States and some of the States that traditionally have been very conservative in their practice style, like Minnesota and Oregon and Utah.

Senator JEFFORDS. Thank you very much.

Senator BREAUX. Senator Reed.

Senator Reed. Thank you very much, Mr. Chairman. Let me summarize quickly two things I have learned about Medicare reform in the last several years. First, no new idea goes unpunished, so I want to commend Senator Breaux and Senator Frist for their courage. Second, you really have to begin to worry when you think you understand the Medicare system. That is when you should get nervous.

So with that as a preface, let me ask a question. Mr. Goeser's your comments in response to both Senator Lincoln and Senator Jeffords indicate that Medicare is not even covering your costs. And HCFA despite the 100,000 pages of regulations, has lower overhead than most private insurers, and yet it is not covering hospital and provider costs.

The proposals we are entertaining today suggests that private insurance can cost more efficient than the existing Medicare system. Are they going to save money by paying you less or are they going to save the system money by requiring beneficiaries pay more, or some combination of the two? Again, with the notion of this being an infinitely complex issue, I wonder if Mr. Goeser, Dr. Wilensky and Mr. Walker could comment on how are we going to save this money if this already low-overhead national system is not even paying you your costs now.

Mr. GOESER. Well, obviously, the concern that I have reading through the material is that we will set a national weighted average. There will be a premium set for rural Iowans, in my case, and that will be higher than what it has been actually costing them or the Government to provide the care to them.

Now, what happens to that money? Does it actually get passed on to the provider to provide the care or does it just stay in the system for administrative costs? Like I said earlier, premium reform does not equate to provider payment reform, and that is an issue that I think we have to look at very carefully.

Senator REED. Are you getting compensated by private insurers now at cost?

Mr. GOESER. Yes.

Senator REED. And that is through negotiations?

Mr. GOESER. Well, actually, you know, we have very little managed care. The managed care that we do have is in the form of PPOs. We also run our physicians clinic. Nearly every panel that I see of fee schedules, the fee that they will allow is at or above our charges. So it isn't like there are big discounts there because of our pricing mechanisms. The same is true in the hospital. A discount from fees is running in 2 percent, 2.5 percent, from charges.

Senator REED. Dr. Wilensky, your comments about where are these savings would come from.

Ms. WILENSKY. Let me explain why the low administrative costs that you cite of HCFA is, in fact, true, probably too low in the sense that there aren't monies set aside for adequate payment safeguards or quality standards. It does also result in the Federal Government attempting to figure out the right price for each and every service that is provided and whether it ought to have occurred and whether the quality was appropriate and has resulted in the 133,000 pages of regulation. That is the world that you deal in.

If it is possible to do better in another world, it is because you can do tradeoffs without having the micromanagement from above. Instead of waiting until you have an illness, can you use disease management up front? Can you have various kinds of preventive programs? If you have an easier way to make tradeoffs between home care and physicians, will you cut out some of the expensive stuff?

If you allow private fee-for-service plans like the Federal employees plan does, will you be able to have some of the alternatives that are not managed care but that are not the Government-regulated strategies that we now see in fee-for-service?

At least the appeal to me is if the private plans can't do as well as traditional Medicare, traditional Medicare is there for people to choose, either because they feel more comfortable or because it is a better buy, and you don't try to push it out of the system.

Senator REED. Well, let me respond. First of all, the managed care revolution emphasized preventive care and saving money, which has been realized to a degree but not, I think, completely. But I also think if you look at the population where preventive care really has a big payback, it is not 65 and beyond. There is some payback, but these are people who typically, because of age, are getting chronic diseases that require constant care. So I don't know if we are going to save a lot of money from preventive care.

Ms. WILENSKY. But disease management can make a huge difference.

Senator REED. Well, I would note that United Health decided last year, after spending \$100 million in utilization management and denying 1 percent—in fact, approving 99 percent of the doctors' suggestions—that they were going to eliminate the system.

Frankly, I don't know about my colleagues, but what I hear from my constituents enrolled in managed care is the hassles they have from this managing of their care, and some would say managing their costs. Again, I think we have an obligation to thoroughly con-

sider any type of reform that can potentially stabilize the system and give people better access to care, but I am not totally convinced that we can do any better or significantly better. But I am here to listen.

General Walker.

Mr. WALKER. Macro and micro, Senator. I guess on a micro basis, if you take Breaux-Frist, there is intended to be greater competition among providers which is likely to have more of an effect on urban areas, in all likelihood, for reasons that have been articulated.

Second, there is intended to be greater transparency, greater choice of individuals between the level of coverage that they get, and incentives such that if they want more expensive benefit programs, they are going to pay more. And if they choose less expensive programs, they are going to get subsidized more. That should affect across the board. But as we found out today, there are very real issues between urban and rural that have to be looked into.

Senator REED. I know my time has expired. However, one point I would like to raise quickly is that in some cases the difference between urban and rural in terms of competition is not a difference. In my State of Rhode Island, we had one of our largest insurance companies fail, Harvard Pilgrim. We effectively have two insurance companies, Blue Cross and United. And some suspect that United might withdraw not because they are in difficult straits, but because they are not making enough money.

So, effectively, we could have in my State, like Iowa, one insurance company, and I ask you where is the competition?

Mr. WALKER. I understand, Senator. We are talking today about Medicare. Candidly, at some point in time we are going to have to engage in a discussion about fundamental issues with regard to health care economics, and that issue that I talked about, the differences between wants, needs, and afford, including this issue among others.

Senator REED. Thank you.

Senator BREAU. I thank the panel. Of course, I would just add one quick point. I mean, in areas where we don't have private managed care because it is rural or because it is not in their interest to go into those areas, people will still have the traditional Medicare fee-for-service, with all of the benefits and all of the price controls and everything else.

I thank this panel very much. You have been very, very helpful. We appreciate your being with us.

We would like to welcome up our next panel dealing with prescription drugs. We would like to welcome up Dr. Beatrice Braun, who is the board of directors for the American Association of Retired Persons; Mr. Mitchell Daniels, Jr., who is senior vice president of Corporate Strategy and Policy at Eli Lilly; and Ms. Debbie Steelman, who is president of Steelman Health Strategies, and I would mention also a former member of the National Bipartisan Commission on the Future of Medicare.

So, ladies and gentlemen, we welcome you and look forward to receiving your testimony.

Dr. Braun, we have you listed first and we would be pleased to hear from you.

STATEMENT OF BEATRICE BRAUN, M.D., MEMBER, BOARD OF DIRECTORS, AMERICAN ASSOCIATION OF RETIRED PERSONS, WASHINGTON, DC

Dr. BRAUN. Thank you, Senator. I am Bea Braun from Spring Hill, FL, and as the Senator said, I am a member of the AARP's Board of Directors, and I am very grateful for being able to testify today.

Since it was enacted 35 years ago, Medicare has positively changed the lives of older and disabled Americans, as we realize. It has provided access to affordable health care and kept many older people out of poverty. But there are challenges now facing Medicare, and among the most significant are ensuring that the benefits keep pace with the rapid advances in medicine and that the program remains dependable and affordable for beneficiaries.

As a retired physician, I have seen the practice of medicine change dramatically since Medicare was created, particularly in the area of prescription drugs. Simply stated, prescription drug coverage is smart medicine. Yet, while most employer plans include drug coverage, Medicare does not. And if you think about it, we would never design a benefits package today without having a pharmaceutical benefit.

We are pleased that Congress, the administration, and the drug industry all recognize that prescription drug coverage must be a part of a strengthened Medicare program. The only question is how to do it. AARP believes that a Medicare prescription drug benefit has to be available to and affordable for all beneficiaries. It should be voluntary, allowing people to keep the coverage they currently have. The benefit must be affordable for all beneficiaries and not just those with low incomes.

The benefit needs to ensure that it helps middle-income beneficiaries handle mounting prescription costs. Equally important, it needs to ensure enough participation in the benefit to avoid risk selection. One of Medicare's greatest strengths has been its success in pooling the risk of nearly 40 million beneficiaries. This is how Medicare avoids the cherry-picking that exists in today's under-65 health insurance market. This broad risk pool in the full Medicare program and in a new prescription drug benefit must be sustained in order to keep Medicare strong and affordable.

While 65 percent of beneficiaries have some type of drug coverage, it is often inadequate, it is often limited, and it is expensive and increasingly becoming unstable. In fact, in 1996, as we heard this morning, only 53 percent of beneficiaries actually had continuous drug coverage for an entire year.

Employer-based retiree coverage is declining rapidly. Medigap coverage is expensive, it is limited in what it covers, and managed care coverage has proven unstable, as we see by the lowering of benefits and by the last 2 years of pullouts.

My written statement elaborates on AARP's prescription drug principles, as well as our principles on Medicare reform. I am not attempting today to give a full review of the bill introduced by Senators Breaux and Frist. That would take a lot more hearings. But I would stress that as Congress undertakes that effort, a careful, thorough beneficiary impact statement will be essential.

The Breaux-Frist proposal improves upon early versions of the proposal, and particularly by providing a modest subsidy for all beneficiaries who elect the high-option plan. But for beneficiaries, this step does not eliminate many important questions and concerns about the proposal, and among the questions are how and to what extent would the bill improve Medicare's long-term solvency, to what will a Government contribution assure adequate choice over time without regard to where beneficiaries live, and is the 25-percent premium subsidy enough to make the benefit affordable for most beneficiaries and to ensure a viable risk pool.

Since the drug benefit is pegged to actuarial costs and is not a defined benefit, how would insurers be prevented from cherry-picking? The bill relies heavily on risk adjusters to assure appropriate payments to plans and we don't yet have dependable risk adjustment and it is a ways off, and so how would appropriate payment to plans be calculated prior to the development of risk adjusters?

And to whom would the new Medicare Board be accountable, and how much discretion would that Board have? The bill would cap general revenues into Medicare at 40 percent of Medicare spending. What would be the impact of this general revenue spending cap on payments to providers and plans, on beneficiaries' premiums, cost-sharing and/or benefits, and ultimately on Medicare's entitlement?

AARP is reserving judgment on the Breaux-Frist proposal until these and other questions are answered. We believe it is important to thoroughly examine the proposal, and also the President's plan and all the other proposals that have emerged. In fact, it would be a serious mistake for anyone to hinder debate or for Congress to rush to judgment on any reform option.

If legislation is pushed through too quickly, before the effect on beneficiaries and the program is known and before there is an emerging public judgment, AARP would be compelled to alert our members of the dangers in such legislation and why we could not support it.

Mr. Chairman, AARP is committed to working with Members of Congress on a bipartisan basis to make Medicare stronger. We look forward to working with this committee and the Congress.

Thank you very much.

[The prepared statement of Dr. Braun follows:]



TESTIMONY BEFORE THE
SENATE SPECIAL COMMITTEE ON AGING

ON

THE NEED FOR MEDICARE REFORM AND
A PRESCRIPTION DRUG BENEFIT

FEBRUARY 8, 2000

WASHINGTON, D. C.

WITNESS: BEATRICE BRAUN, M.D.
AARP BOARD MEMBER

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Mr. Chairman and members of the Committee, I am Beatrice Braun, a member of AARP's Board of Directors. I appreciate the opportunity to share with you AARP's perspective on some of the broader issues involved in reforming the Medicare program, and in particular, on the need for Medicare prescription drug coverage.

For over thirty years Medicare has provided older and disabled beneficiaries with dependable, affordable, quality health insurance. I live in Florida, which has one of the largest beneficiary populations in the nation. As a retired physician, I have seen first hand how Medicare has made a difference in the lives of older Americans. Medicare has been instrumental in improving the health and life expectancy of beneficiaries in Florida and across the nation. It has also helped to reduce the number of older persons living in poverty.

Medicare's promise of affordable health care extends beyond the current generation of retirees. Now, more than ever, Americans of all ages are looking to Medicare's guaranteed protections as part of the foundation of their retirement planning. AARP believes that in order for Medicare to remain strong and viable for today's beneficiaries, and for those who will depend on it in the future, we must confront the key challenges facing the program.

Foremost among these challenges is ensuring that Medicare's benefits and its means of delivering care remain dependable even as they are updated to keep pace with the rapid advances in health care. The practice of medicine has changed dramatically since the Medicare program was created. We are now living in a time of amazing breakthroughs in medical technology. Each time I pick up a newspaper or turn on the television there are stories about new procedures or therapies that could improve the lives of millions of Americans. Among the most striking are the advances in the area of prescription drugs. Drug therapies that were not available when Medicare began are now commonly used to prevent, treat, and control illnesses. As a result, prudent reliance on prescription drugs now goes to the very core of good medical practice.

Ironically, while older Americans typically need more medications than younger people, most employer plans include and rely on prescription drug coverage as an essential tool for medical management, but Medicare still does not. Prescription drug coverage must be part of an improved Medicare program. Simply stated, prescription drug coverage is smart medicine.

The second challenge facing Medicare is our nation's changing demographics. The retirement of the baby boom generation will nearly double the number of Medicare beneficiaries in the program. Medicare's financing and delivery systems must be capable of serving this enormous influx of beneficiaries whose health care circumstances, needs, and expectations will be similar in some respects to those of today's beneficiaries, but very different in others. Just as important, longer life spans are already causing rapid growth in the very old population. Medicare must be prepared to handle the unique health care needs of a growing number of older Americans who reach 85, or even 100.

To meet the first two challenges, the program's long-term financial solvency must be secure. AARP supported the Balanced Budget Act of 1997 as a first step towards securing Medicare's long-term solvency. The strong economy we now enjoy, and the Medicare Trustees' projection of solvency to the year 2015, is good news. But, this does not mean we can afford to become complacent or that we can delay the debate over how best to strengthen Medicare.

The deliberation over Medicare's future must be ongoing. It will take a sustained effort to continually update and improve Medicare. Changing a program that millions of Americans depend on for their health care is no small task. There must be a careful and thorough examination of the full range of issues – including how the issues interact and impact beneficiaries – and a similarly careful effort to make sure that policy makers and the public alike understand the trade-offs that will be necessary.

The competitive premium proposal introduced by Senators Breaux and Frist, the President's proposal, and other emerging legislative proposals, provide opportunities for examining different reform options and for stimulating debate. Genuine debate over the issues and options surrounding Medicare are critical to building public understanding and support for reform. AARP believes that it would be a serious mistake for anyone to hinder debate on such proposals or, by the same token, for Congress to rush to judgment on any reform option.

Lessons Learned

As promising reform options emerge, it is only reasonable to test those ideas so we more fully understand the impact on Medicare beneficiaries and the program in general. A high priority must be to ensure that reform proposals actually work, and cause minimum disruption for beneficiaries and Medicare. Whenever possible, changes to Medicare should be tested and evaluated on a smaller scale before being incorporated into the full program. Pilot testing can help to identify potential problems and provide the opportunity for making necessary refinements before the changes are made program-wide.

Further, it is important that changes be given time to be assimilated into the program, and their impact be assessed, before new modifications are layered on top. Every change to Medicare will bring unintended consequences. Only two years after enactment of the sweeping changes made by the Balanced Budget Act (BBA) of 1997 – many of which were still being implemented – Congress significantly modified these provisions with passage of the Balanced Budget Act Revisions of 1999. Mid-course changes of this magnitude can create administrative complexities as well as confusion and disruption for Medicare's nearly 40 million beneficiaries. Policy makers and the public must understand proposed changes and their anticipated effect, first and foremost on beneficiaries, but also on providers and on the Medicare program in general. As we all learned from the legislative debates over the recent BBA revisions, earlier experiences with the Catastrophic Coverage Act in the late 1980s, and

from the health care reform debate of the early 1990s, unless the American public understands the trade-offs they are being asked to make, initial support can erode quickly.

The Need for a Medicare Prescription Drug Benefit

This Committee plays an important role in identifying issues of concern to older Americans. AARP hopes today's hearing will help focus attention on the need for a Medicare prescription drug benefit as well as other Medicare reform issues.

Pharmaceutical therapies have become increasingly important in the treatment of virtually every major illness. In many cases, new drugs substitute for or allow patients to avoid more expensive therapies such as hospitalization and surgery. In other cases, drugs facilitate treatment or provide treatment where none existed before, thus improving the quality and length of life for the patient. Breakthroughs in prescription drug treatments are happening in many areas. From Alzheimer's and arthritis to heart disease and the flu, new prescription drugs are becoming available to treat and even prevent serious conditions and life-threatening illnesses.

The need for prescription drug coverage is especially important for older Americans. Eighty percent of retirees use a prescription drug every day. While older Americans comprise only 12 percent of the U.S. population, they account for one-third of prescription drug spending. In fact, prescription drugs account for the single largest component of health care out-of-pocket spending, after premium payments, for non-institutionalized Medicare beneficiaries age 65 and older. On average, these beneficiaries are expected to spend as much out-of-pocket for prescription drugs (17 percent of total out-of-pocket health care spending) as for physician care, vision services, and medical supplies combined. By contrast, inpatient and outpatient hospital care each accounts for about 3 percent of older beneficiaries' total out-of-pocket health spending.

High use, high drug prices, and inadequate insurance coverage pose serious problems for today's Medicare beneficiaries. In fact, some beneficiaries are forced to choose between food and their medications. Others do not refill their prescriptions or take the proper dosage in order to make their prescriptions last longer. A chronic health problem necessitating some of the newest, most expensive prescription drugs can deplete a retiree's financial resources.

Because of Medicare's current lack of prescription drug coverage, many beneficiaries must pay for prescription drugs completely out-of-pocket. Other beneficiaries obtain private supplemental coverage that assists with costs or join a Medicare HMO that offers a prescription drug benefit. It is also important to understand that those Medicare beneficiaries without coverage pay top dollar for their prescriptions because they do not benefit from discounts negotiated by third party payers as do most younger persons.

Although 65 percent of Medicare beneficiaries have *some type* of coverage for prescription drugs, this figure can be very misleading. Many current prescription drug coverage options are inadequate, restricted, expensive, and unstable. In fact, the majority of Medicare beneficiaries – not just those with low incomes – need drug coverage. Why?

First, Medicare beneficiaries' current prescription drug coverage does not protect them from high out-of-pocket expenses. AARP estimates that 25 percent of Medicare beneficiaries spent over \$500 out-of-pocket on prescription drugs in 1999, and over half of these beneficiaries had some type of coverage. Forty-two percent of beneficiaries who spent \$1,000 or more had some type of drug coverage. For example, some beneficiaries buy Medigap policies that provide a drug benefit. But, the premiums on these policies often exceed \$1,000 a year and the coverage is quite limited. Two of the three Medigap policies that cover prescription drugs have an annual cap of \$1,250 on drug coverage; the third policy has a \$3,000 cap. All three Medigap policies that have a prescription drug benefit require the beneficiary to pay 50 percent coinsurance. Other

beneficiaries choose to enroll in Medicare HMOs that offer some prescription drug coverage. Yet, this year 32 percent of Medicare HMOs offering drug coverage have a \$500 cap that applies to brand or brand and generic drugs, and average copays in these plans have increased dramatically from last year – an estimated 21 percent for brands and 8 percent for generics.

Second, current prescription drug coverage available to Medicare beneficiaries is limited. Private Medigap policies may be the only option for obtaining drug coverage for beneficiaries who do not have access to employer coverage or Medicare+Choice plans. Yet, because almost all Medigap policies with drug coverage are medically underwritten, many Medicare beneficiaries desiring such coverage cannot obtain it. Although Medicare HMOs are prohibited by law from underwriting the coverage they offer, such plans are not available in all parts of the country.

Third, current drug coverage options are not stable. For example, beneficiaries who obtain prescription drug coverage from their former employer are finding that coverage to be unstable. Retiree health benefits that include prescription drug coverage are becoming more scarce. While an estimated 60 to 70 percent of large employers offered retiree health coverage during the 1980s, fewer than 40 percent do so today. Of those employers who offer retiree benefits, 28 percent do not offer drug coverage to Medicare eligible retirees.

Further, beneficiaries who have drug coverage through Medicare HMOs cannot depend on having this coverage from year to year as their plans can change their benefits on an annual basis or even terminate their participation in Medicare. For example, this year many beneficiaries in Medicare+Choice plans are living through abrupt changes in

their prescription drug coverage that they did not foresee when they enrolled. Some of the most visible of these changes include:

- Increasing premiums - Over the past few years, more and more Medicare+Choice plans are charging premiums for their coverage, and those premiums are climbing. This year 207,000 beneficiaries must pay over \$80 per month to enroll in a Medicare HMO. This compares to 1999 when only 50,000 Medicare beneficiaries enrolled in Medicare HMOs had a minimum premium above \$80 per month.
- Higher cost-sharing - For the first time this year, all Medicare HMOs are charging copays for prescription drugs and the average beneficiary copay has increased significantly.
- Decreasing benefit - The annual cap on the typical Medicare+Choice drug benefit has decreased. While in 1999 only 21 percent of Medicare HMOs had an annual cap of \$500 or less on their drug benefit, this year 32 percent of plans will have a \$500 cap.
- Loss of benefit - This year some Medicare+Choice plans dropped their prescription drug benefit entirely. Although Medicare+Choice has provided beneficiaries with an opportunity for drug coverage, the volatility of the Medicare+Choice market has made that coverage unpredictable and unstable from year to year.

Finally, as reported in a new study by the Commonwealth Fund, many Medicare beneficiaries do not have continuous prescription drug coverage. In 1996, just 53 percent of beneficiaries had prescription drug coverage *throughout* the year.

Issues Surrounding Adding Prescription Drugs to Medicare

AARP is committed to creating an affordable Medicare prescription drug benefit that would be available to all beneficiaries, so that they may benefit from longer, healthier lives, fewer invasive medical procedures, and reduced health care costs. We appreciate the Committee's interest in this issue and look forward to working with the Congress and the Administration to assure that a prescription drug benefit that is available and affordable to all Medicare beneficiaries becomes part of Medicare's defined benefit package. To that end, we have identified what we believe are the fundamentals of a Medicare prescription drug benefit:

- A Medicare prescription drug benefit must be *available* to *all* Medicare beneficiaries. First, the benefit should be *voluntary* so that beneficiaries are able to keep the coverage that they currently have, if they choose to do so. A Medicare prescription drug benefit should not be an incentive for employers to drop or cut back on retiree health coverage. Second, the benefit needs to be *affordable* to assure enough participation and thereby avoid the dangers of risk selection. To this end, the government contribution will need to be sufficient to provide a premium that is affordable, and a benefit design that is attractive to beneficiaries. In other words, this is not simply a matter of beneficiary affordability, but equally important, the fiscal viability of the risk pool. Medicare Part B is a model in this regard. The Part B benefit is voluntary on its face, but Medicare's contribution toward the cost of the benefit elicits virtually universal participation.
- Prescription drugs should be part of a defined benefit package. It is critical that beneficiaries understand what is included in their benefit and that they have dependable and stable prescription drug coverage.
- The benefit must assure beneficiaries have access to medically appropriate and needed drug therapies.

- The benefit must include quality improvement components to reduce medical errors and mismedication and to help reduce overall health care costs.
- The benefit must include meaningful cost-containment mechanisms for both beneficiaries and Medicare. This should include drug-purchasing strategies that enable Medicare beneficiaries and the program to take advantage of the aggregate purchasing power of large numbers of beneficiaries.
- The benefit must provide additional subsidies for low-income beneficiaries to protect them from unaffordable costs and assure that they have access to the benefit.
- The benefit must be financed in a fiscally responsible manner that is both adequate and stable. AARP believes that an appropriate amount of the Federal budget surplus should be used to help finance a prescription drug benefit.
- A new prescription drug benefit should be part of a strong and more effective Medicare program. Prescription drug coverage must be integrated into the program in a manner that strengthens Medicare. Prescription drug coverage must also improve Medicare's ability to support modern disease management and prevention strategies. Many of these strategies hold promise to both increase health outcomes and lower program costs.

Key Principles That Should Guide Broader Medicare Reform

As this Committee also examines the broader issue of reforming Medicare, AARP urges you to consider the fundamental principles that, since Medicare's inception, have helped to shape it into such a successful program. We believe strongly that these principles must be the basis of any viable reform option.

Defined Benefits Including Prescription Drugs

All Medicare beneficiaries are now guaranteed a defined set of health care benefits upon which they depend. A specified benefit package that is set in statute is important for a number of reasons. First, it assures that Medicare remains a dependable source of health coverage over time. Second, a defined benefit package serves as an important benchmark upon which the adequacy of the government's contribution toward the cost of care can be measured. Without this kind of benchmark, the government's contribution could diminish over time, thereby eroding Medicare's protection. Third, a benefit package set in statute reduces the potential for adverse selection by providing an appropriate basis for competition among the health plans participating in Medicare. And finally, a defined benefit package provides an element of certainty around which individuals, employers, and state Medicaid programs may plan.

As was laid out earlier in this statement, because prescription drugs are central to the delivery of high quality health care, Medicare should be like most other health insurance plans and include prescription drugs as part of Medicare's defined benefit package offered by all participating plans – including traditional fee-for-service.

Adequate Government Contribution Toward the Cost of the Benefit Package

It is essential that the government's contribution or payment for the Medicare benefit package keep pace over time with the cost of the benefits. Currently, payment for traditional Medicare is roughly tied to the cost of the benefit package. If the government's contribution were tied to an artificial budget target and not connected to the actual cost of the benefit package, there would be a serious risk of both the benefits and government payment diminishing over time. The effect of a flat government payment – regardless of the plan cost – could be sharp year-to-year premium and cost-sharing increases for beneficiaries. It could also mean significant differences in what beneficiaries would have to pay for different Medicare plans.

Out-of-Pocket Protection

Changes in Medicare financing and benefits should protect all beneficiaries from burdensome out-of-pocket costs. Medicare beneficiaries age 65 and over, spent on average, about \$2,430 – nearly 20 percent of their income – out-of-pocket for health care expenses in 1999, excluding the costs of home care and long-term nursing care. In addition to items and services not covered by Medicare, beneficiaries have significant Medicare cost-sharing obligations: a \$100 annual Part B deductible, a \$776 Part A hospital deductible, 20 percent coinsurance for most Part B services, a substantially higher coinsurance for hospital outpatient services and mental health care, and significant coinsurance for skilled nursing facility care and very long hospital stays. Currently, there is no coinsurance for Medicare home health care.

AARP believes that Medicare beneficiaries should continue to pay their fair share of the cost of Medicare. However, if cost-sharing were too high or varied across plans, Medicare's protection would not be affordable, and many beneficiaries would be left with coverage options they might consider inadequate or unsatisfactory.

Viable Fee-for-Service

Medicare beneficiaries must continue to have access to a strong and viable fee-for-service option. Managed care is not yet established as a fully satisfactory choice for many beneficiaries. In addition, many beneficiaries live in areas of the country where managed care plans are not available or likely to become available soon. Without an affordable fee-for-service option, these beneficiaries could end up paying as much or more out-of-pocket for health care coverage that does not meet their needs.

Protecting the Availability and Affordability of Medicare Coverage

Medicare should continue to be available to all older and disabled Americans regardless of their health status or income. Our nation's commitment to a system in which Americans contribute to the program through payroll taxes during their working years and then are entitled to receive the benefits they have earned is the linchpin of public

support for Medicare. Denying Medicare coverage to individuals based on income threatens this principle. Similarly, raising the age of Medicare eligibility would have the likely affect of leaving more Americans uninsured. Thus, in the absence of changes that would protect access to affordable coverage, AARP views it as unacceptable to raise the eligibility age for Medicare. Analogies to Social Security's increasing age of eligibility simply do not apply. Social Security's early retirement benefits – though actuarially reduced – start at age 62, and most retirees today begin to collect benefits at age 62 not at age 65.

Administration of Medicare

Effective administration of the program remains essential. The agency or organization that oversees Medicare must be accountable to Congress and beneficiaries for assuring access, affordability, adequacy of coverage, quality of care, and choice. It must have the tools and the flexibility it needs to improve the program – such as the ability to try new options like competitive bidding or expanding centers of excellence. It must ensure that a level playing field exists across all options; modernize original Medicare fee-for-service so that it remains a viable option for beneficiaries; ensure that all health plans meet rigorous standards; and continue to rigorously attack waste, fraud and abuse in the program.

Financing

Medicare must have a stable source of financing that keeps pace with enrollment and the costs of the program. Ultimately, financing sources will need to be both broadly based and progressive. Additionally, because health care costs are rising faster than productivity, AARP supports using an appropriate portion of the on-budget surplus to secure Medicare's financial health.

The Breaux-Frist Proposal

We have not attempted in this testimony to undertake an extensive review of the Breaux-Frist proposal, and the full range of questions that it raises. That essential step will require many more hearings, close review by a range of experts, and careful assessment of the impact of the proposed changes on Medicare beneficiaries, plans and providers, and the program itself.

AARP commends Senators John Breaux and Bill Frist for their efforts to ensure that Medicare reform remains a priority. While critical questions remain, S.1895 includes several improvements over earlier versions of the proposal, including a modest (at least 25 percent) subsidy for all beneficiaries who choose to take the high option plan with prescription drugs. Among the fundamental questions that must be answered and their impact assessed are:

- How and to what extent would S. 1895 improve Medicare's long term solvency?
- Medicare beneficiaries who elect to stay in the HCFA-sponsored program would be guaranteed a defined benefit that includes Medicare's current benefits. However, beneficiaries who choose other plans could experience "reasonable variation in cost-sharing." What constitutes "reasonable variation" and how would this affect beneficiaries? Would this difference between the HCFA-sponsored plan and other plans put the traditional Medicare fee-for-service program and its beneficiaries at risk?
- To what extent will the government contribution assure adequate choice for beneficiaries over time, without regard to where they live?
- Is the prescription drug benefit affordable? Is a 25 percent premium subsidy enough to make the benefit affordable for most beneficiaries and to assure a viable risk pool?

- Because the drug benefit would be pegged to actuarial cost and not to a particular benefit design (e.g., deductible, cost sharing, stop-loss protection, etc.), it appears that the drug benefit could be designed in different ways by different high option plans. How, then, would insurers be prevented from "cherry picking" beneficiaries through the design of their drug benefit?
- How will the proposal protect beneficiaries who live in high cost areas where all high option plans have premiums above the national weighted average?
- Because the high-option stop-loss protection does not extend to the prescription drug benefit, how would beneficiaries who have very high drug costs be protected?
- S.1895 relies heavily on risk adjusters to assure appropriate payment to plans. Given that dependable risk adjustment is still in development – and probably will be for some time – how would risk and geographic adjusters be calculated? How would appropriate payment to plans be calculated prior to the development of fully functional risk adjusters?
- To whom would the new Medicare Board be accountable? How much discretion would the Board have in making changes in program policy to respond to changing market conditions?
- What is the rationale for establishing a new "solvency standard?" The bill would cap Medicare general revenue at 40% of Medicare spending. What would be the impact of this general revenue spending cap on payments to providers and plans? On beneficiaries' premiums, cost-sharing, and/or benefits? How would this be determined? What would be the impact of this cap on Medicare's entitlement?
- As a practical matter, how would premiums that vary by plan be deducted from individual Social Security checks? Would this be administratively feasible?

Because the Breaux-Frist proposal continues to be refined, AARP is reserving final judgment on the plan until further questions about its impact on Medicare beneficiaries and the Medicare program are answered.

Conclusion

The Medicare program needs to be ready to meet the unique challenges it now faces now and in the future. Foremost among the challenges is ensuring that, even as the program adjusts to ensure its future financial soundness, it must also adjust to keep pace with the rapid advances in medicine. Therefore, AARP believes that an affordable Medicare prescription drug benefit that is part of Medicare's defined benefit package and available to all Medicare beneficiaries is essential to any Medicare reforms.

Finally, the success of any changes to Medicare and the long-term strength and stability of the program depend on a good understanding – on the part of the public and policy makers alike – of the changes that are being contemplated. This will require not only extensive dialogue, but also a thorough analysis of how the proposed changes would affect current and future beneficiaries – including the chronically ill, the poor and near-poor, and those who live in rural America.

If legislation is pushed through too quickly, before there has been a thorough examination of the effect on beneficiaries and the program, and before there is an emerging “public judgment” about the changes, this would be a very serious mistake. In such a circumstance, we would be compelled to alert our members to the dangers in such legislation and why we could not support it.

AARP looks forward to continuing to work with members of this Committee and the Congress to advance the debate over Medicare reform and prescription drug coverage, and to carefully explore the best options for securing Medicare's future.

The CHAIRMAN. Mitch.

STATEMENT OF MITCHELL E. DANIELS, JR., SENIOR VICE PRESIDENT, CORPORATE STRATEGY AND POLICY, ELI LILLY AND COMPANY, INDIANAPOLIS, IN

Mr. DANIELS. Thank you, Senator. I am Mitch Daniels, Lilly's senior officer for policy, long-term planning, and major business transactions. And for several years prior to this post I was president of our North American pharmaceutical operations which, of course, includes the market in which Medicare operates.

All Americans should be grateful for the courage and initiative of those on this committee who are leading the effort to create a new era of better health for our Nation's elderly. You are all experts who need no enlightenment from me about the Medicare dilemma. My assignment, I take it, is to address one of the worst failures of the system, its failure to assure patients access to the best tools of today's health care, modern pharmaceuticals.

At Lilly, we emphatically support balancing the care equation by incorporating prescription coverage within a reconstructed Medicare. Everyday, this omission tilts millions of individual decisions away from drugs that seniors need and toward more expensive interventions or, worse still, inaction.

Three principles and one absolute should govern this needed change. Reform should be comprehensive, not piecemeal. Tacking a drug benefit, especially the wrong one, onto today's Medicare would be to put a shiny hood ornament on a smoking jalopy. Reform should foster the integration of care. Separating decisionmaking and budgeting for drugs from that for other interventions is senseless from both a patient and an economic standpoint. Reform should maximize patient choice. In an era of informed consumerism, the mentality that would herd all beneficiaries into one inflexible system is hopelessly obsolete.

Finally, the absolute: no price controls, not by name, not by indication, not by accident, not by stealth, not by baby steps. I appreciate the powerful attraction of policies that dole out largess today for costs which are distant and invisible, and that is drug price controls to a tee; smiles and cheers on the day of enactment, but no Member of Congress will be held accountable for the cures that never come.

A quick word about pending legislation. The Breaux-Frist bill is the most insightful and encouraging starting point to date, meeting the tests of comprehensiveness, integration of care, and choice. Its principle defect lies in stopping short, leaving much of today's antique system in place in perpetuity.

The administration's proposal has larger shortcomings, failing all three tests. It would freeze today's failing system in place, extend the error of segregating drug therapy from other treatment options, and say take it or leave it to seniors who deserve choices as diverse as their circumstances. Moreover, its legislated monopolies would quickly impose price controls by proxy, with all their unacceptable consequences.

We know that Congress may be tempted to evade or postpone thorough change of Medicare and default to a mere drug-only benefit. This would be a missed opportunity and a severe disappointment.

ment. Any such stop-gap measure should be designed for consistency and a smooth transition to the comprehensive, integrated system that must eventually come if seniors are to get the best care possible.

Lilly endorses true Medicare reform, recognizing that our business environment will become even more difficult as a result. Health plans winning the freely chosen business of tomorrow's seniors will have the clout, the motivation, and the medical knowledge to drive hard bargains. Our company, determined to deliver truly novel, innovative, valuable solutions, is prepared to earn its way in that environment. On behalf not just of one company or one industry but of all Americans, we ask you to bring that better world about.

[The prepared statement of Mr. Daniels follows:]

Testimony

of

**Mitchell E. Daniels, Jr.
Senior Vice President
Corporate Strategy and Policy
Eli Lilly and Company**

before the

**Special Committee on Aging
United States Senate**

**Room 562
Dirksen Senate Office Building
Washington, D.C.**

**9:30 am
Tuesday, February 8, 2000**

Thank you, Mr. Chairman and Senator Breaux, for your invitation to be part of this forum. I wish to commend the Committee for engaging in these critically important issues.

Your decisions about the future of Medicare and the addition of a prescription drug benefit will affect millions of Americans.

We at Eli Lilly and Company applaud Senator Breaux's efforts to bring the outdated Medicare program into the twenty-first century. A great deal has changed since Lyndon Johnson signed Medicare into law 35 years ago, and the challenge is immense.

Our basic goal, however, is relatively simple: we must focus on the best interests of the patient. While tremendous strides have been made in medical technology over the past 30 years, comparable progress has not been made in the Medicare benefit structure. When Medicare began in the 1960s, pharmaceutical cures were the exception, not the rule. Long hospital stays were much more common, and outpatient surgery was generally unimaginable. Many conditions easily managed today were largely untreatable then. Preventive care was virtually nonexistent.

Medical advances of all kinds have allowed seniors to live significantly longer and healthier lives. Yet, as dramatic as these advances have been, we are on the brink of new discoveries that will bring even greater benefits. Fueled by advances in our understanding of the life sciences, these discoveries will dramatically improve doctors' abilities to prevent illness and to heal and comfort those who suffer. It is imperative that we have in place a system that provides the benefit of these discoveries to the patients who need them.

If Congress were enacting Medicare anew today, the program would bear no resemblance to its current form. Medicare was designed to guarantee quality health care for our senior citizens, but it is now disconnected, uncoordinated, inadequate, expensive, and

unresponsive. The program has numerous design flaws and perverse incentives that would be unthinkable to someone designing a modern-day health plan. And Medicare beneficiaries suffer as a result.

In many ways, Medicare fails seniors when they need protection the most. It does not include catastrophic coverage, hospital coverage decreases with length of stay, there are no long-term care benefits, it does not pay for most preventive care and its cost-sharing requirements are disjointed. And the first dollar coverage provided by supplemental insurance creates incentives for seniors to utilize care inappropriately. The claims review and appeals process for denied claims is interminable—524 days on average—and its regulatory burden is absurd. Unbelievably, Medicare's rules and regulations are more voluminous than the tax code and pervade every sector of the medical system. For Medicare providers, innovation, efficiency, and quality are discouraged. Mastering the bureaucratic system is the more essential skill.

One glaring deficiency is the lack of coverage for outpatient prescription drugs. Pharmaceuticals play a central role in the modern-day practice of medicine. With the promise of future discoveries clearly in sight, pharmaceuticals may soon become the single most necessary component of health care, especially for seniors. Indeed, they may already be.

Medicare's lack of prescription drug coverage is bad health care, bad public policy, and, apparently, bad politics. The absence of coverage for prescription drugs often creates perverse incentives that favor more costly and invasive treatments. While many seniors have prescription drug coverage from other sources, for some the financial burden of paying for their medicines is significant. This issue presents a significant challenge to both government and industry: we must find a way to ensure access for all our citizens to the breakthrough medicines that enhance and extend life, while at the same time maintaining today's momentum and American leadership in the discovery and development of new cures.

At its very core, Medicare is a government-run health system that relies on the failed strategy of bureaucratic controls instead of private competition. Despite all its rules and price controls, the program is moving toward bankruptcy. Although our currently robust economy may give the system some breathing room, simply adding additional benefits to the existing program without other basic reforms will only accelerate its financial demise and perpetuate a structure that impedes quality, efficiency, coordination, and innovation. Because of its complexity and controversy, we cannot wait until the last minute to shape the solutions.

In light of this urgent agenda for reform, we believe the reinvention of Medicare should be guided by our national experience over the past 35 years:

- We should pursue a comprehensive solution that addresses seniors' total health care needs.
- We should approach health care not piece by piece, but as an integrated whole that helps us learn what improves quality, communication, and convenience, what provides the best results for patients, and what delivers the best economic value.
- We should offer seniors choices of health plans that best fit their particular needs.
- We should stress competition – which fosters innovation and quality. And, above all, we must prevent any possibility of government-imposed price controls that delay and deny care for today's patients – and impede innovation for tomorrow's patients. Price controls would derail medical progress and, insidiously, we would never know what miracles we had missed.

Eli Lilly and Company strongly supports the establishment of an outpatient drug benefit within Medicare. To succeed, however, it must be enacted as part of comprehensive reform and be based on competition among private sector options where beneficiaries can choose the plan they want. We believe that coverage must be provided through market-based insurance that spreads and shares the costs, not through government-imposed price controls, which are doomed to fail to meet any of the key policy goals. In addition, drug coverage must be integrated so that choices are made with the right incentives in mind, beginning with what is best for the patient. A market-based system can ensure a fiscally sound Medicare program that provides seniors the care they need now and in the future.

Although drug benefits, in isolation, may be more politically attractive in this campaign season, a viable, sustainable senior drug benefit ultimately requires comprehensive reform. Congress must decide on the pace of that reform. If Congress decides to adopt a drug benefit as a stop-gap, incremental step, it must at the very least ensure that the drug benefit will work as part of an eventual comprehensive overhaul.

As you undertake these deliberations, we urge the Congress to consider several basic factors that emerge from this country's recent experience. First, few forces have proven more powerful or more beneficial than genuine consumer choice. People desire and deserve to make the best decisions for themselves. Second, the recent surge of medical innovation which has improved and saved so many lives is just beginning. Under positive conditions, health care progress will continue to accelerate. Lastly, progress here as everywhere is best driven by the incredible fertility of effective competition among private sector entities.

I. Importance of the National Bipartisan Commission on the Future of Medicare

The National Bipartisan Commission on the Future of Medicare, which began its deliberations on March 6, 1998, is the latest and most significant attempt by Congress and the Administration to address the critical issues facing the Medicare program. As we

all are aware, beginning in the year 2011, the Baby Boom Generation (77 million Americans) starts to enter the Medicare program, presenting significant challenges to the solvency of the program. Clearly, issue number one faced by the Commission was how to devise a set of policies to ensure the continuation of the program while providing high-quality medical care to the elderly and disabled.

An equally important and interrelated issue was how to modernize the Medicare benefit package and the delivery of medical services. The Medicare program currently has an outdated benefit design that has not significantly changed since its inception in 1965. One key omission is the absence of an outpatient prescription drug benefit. As Senator Breaux stated last year, "Prescription drugs are as important today as a hospital bed was in 1965." President Clinton agrees: "Since Medicare's founding in 1965, a medical revolution has transformed health care in America. Once the cure for many illnesses was a scalpel; now just as likely it's a pharmaceutical."

Yet, approaching this problem as a drug-only issue is unwise. Past experience with a drug-only benefit is telling. Let us all recall that in the Medicare Catastrophic Coverage Act of 1988, a prescription drug-only benefit along with protection from catastrophic costs was enacted into law. Because of unsound structure and financing of the benefit, it was repealed, amid great public outcry, approximately one year later. As the Commission recognized, true success can only come from comprehensive modernization of the system.

As we are all aware, Medicare today is still predominantly a fee-for-service delivery system administered by the Health Care Financing Administration (HCFA) through the use of administered pricing. For many Medicare beneficiaries, particularly in rural areas, there still is very little choice of comprehensive health plans that are tailored to their needs rather than those of government.

After more than 12 months of deliberation, a majority of the Commission issued its report on March 16, 1999. The Commission majority recommended a transition from the current antiquated 1960s Medicare delivery system to one that looked similar to the Federal Employees Health Benefits Program (FEHBP), which is currently offered to all Members of Congress and approximately nine million Federal employees, retirees, and their dependents. In this system, health care plans offer a defined minimum set of benefits and compete for beneficiaries who choose the plan which best suits their personal needs. This model, based on market competition and innovation, has proven its ability to offer innovative benefit designs and quality health care at competitive prices. In the FEHBP program, private sector insurers compete for patients, rather than government contracts.

Eli Lilly and Company strongly supports the Commission's majority view that prescription drugs should be provided as an integrated benefit as part of a system that offers seniors a choice of competing private health plans. Lilly also endorses the principles for comprehensive Medicare reform articulated by the pharmaceutical industry in February 1999. Integrated health care is critical because, today, pharmaceuticals are an indispensable part of modern medicine. When a health plan offers an integrated benefit package, it is in a position to make rational and efficient allocations of resource trade-offs to provide the best health care at the lowest possible price. When providers focus on the cost of only a single component, such as drugs, they seek to reduce the cost of that item without proper regard for the effects on patient welfare or costs elsewhere in the system.

For example, atypical antipsychotic medications are revolutionary new medicines for the treatment of schizophrenia. These drugs, however, are considerably more expensive than the old technology, 1960s-era therapies that they replaced. Although costly when considered in isolation, the drugs prove to be a significant value when considered in the greater context. Total annual health care spending drops an average of \$10,300 when patients are prescribed atypical antipsychotic medicines rather than older, conventional

schizophrenia therapies.¹ Simply put, these drugs pay for themselves by savings in other health care costs, including hospitalization. This lesson is lost on the administrator who is only focused on his compartmentalized costs and not the savings to the overall system. In this case, both the system and the patient suffer.

II. "Medicare Preservation and Improvement Act of 1999"

On November 9, 1999, Senators Breaux, Frist, Kerrey, and Hagel introduced S. 1895, the "Medicare Preservation and Improvement Act of 1999," which establishes a Medicare competitive premium system for all Medicare recipients based on the principles endorsed by a majority of the Commissioners. This bill provides both for the creation of a system that offers beneficiaries a choice of competing health plans and for continuation of the traditional HCFA-sponsored Medicare plan. In each system, there are provisions for both standard and high-option plans. The standard plan offers only the core Medicare benefits available under existing Parts A and B of the traditional program. The high-option plan adds outpatient prescription drugs and stop-loss coverage, although the stop-loss coverage applies only to the core benefits and not the drug benefit.

Under the Breaux-Frist bill, the high-option drug benefit will be offered in the private marketplace either directly by private health plans (e.g., private insurance companies, HMOs, etc.) receiving a premium payment from the Federal government for each individual Medicare beneficiary they directly enroll or indirectly by HCFA contracts with private entities to provide the drug benefit to beneficiaries enrolled in a HCFA-sponsored high-option plan. These private entities include insurers, PBMs, and pharmacy networks. They will bear full financial risk for the provision of outpatient prescription drug benefits under the HCFA-sponsored high option plan. The Federal government will pay each private entity a premium for each enrollee and the private entity is solely and exclusively responsible for delivering the benefit.

¹ Obenchain, R.L., Johnstone, B.M. "Mixed-Model Imputation of Cost Date for Early Discontinuers from a Randomized Clinical Trial," *Drug Information Journal* 33, Jan.-Mar. 1999, 191-209.

We at Lilly want to congratulate you, Senator Breaux, and your bipartisan co-sponsors on what we believe is a highly successful legislative translation of the principles embraced by a majority of the Commission members. In particular, we believe that the competitive premium system concept is the right structure for Medicare generally and, with respect to the drug benefit specifically, permits delivery as an integrated benefit within competing health care plans.

We strongly support the overall structure of the competitive premium system model envisioned by your bill; we also believe it is a breakthrough step in addressing Medicare reform. However, as you move through the legislative process, it is very important to make a number of changes if this approach is to work.

We believe the bill should offer stronger incentives for patients to move from traditional Medicare into the competitive premium system. While we recognize the need for a transition period, permanent retention of the current system perpetuates existing deficiencies.

The HCFA stand-alone, high option drug benefit provides incentives that run counter to high quality patient care. Because these HCFA contractors will bear full financial risk for the provision of the drug benefit but not other health care costs, they will be under enormous pressure to limit drug expenditures without regard for patient welfare of savings in other treatment areas. The only way they profit under a drug-only contract is to provide fewer or cheaper drugs. As a result, it can be expected that patients will be required by the system (not by their doctors) to fail on older, cheaper medicines before the latest, most effective drugs are made available to them. While new drugs often reduce hospital, surgical, and other costs, HCFA contractors will see no benefit from these savings and will not bother to use the new drugs or seek those savings. Perversely, their incentive under a drug-only risk contract will be to restrain drug spending whatever the consequences.

The concept of updating the actuarial value of the prescription drug benefit by the increase in the "reasonable cost" of outpatient drugs during the previous years is troublesome. This is an open invitation for the Medicare Board to substitute an arbitrary administrative determination of "reasonableness" for the reality of the medical marketplace.

In addition, the way the bill is currently structured, its stop-loss coverage excludes pharmaceuticals. Because of the importance of pharmaceuticals, and the fact that a few patients require very expensive drug therapies, we believe that medicines should be included in the stop-loss coverage.

Finally, other than authorizing the use of formularies and related cost control mechanisms, the bill is silent on what drugs have to be covered. It is important to ensure that formulary design is based on appropriate clinical guidelines and that patients have access to medicines their doctors believe are medically necessary.

III. Clinton Administration Proposal

In an effort to highlight the need for a drug benefit, the Clinton Administration issued a proposal in July of 1999. This is currently a proposal without any legislative language, but its intended direction is clear. The Administration's proposal would create a new, voluntary Part D Medicare drug benefit, administered by the HCFA through private-sector contractors (eligible PBMs, insurers, and other private entities, which, according to the Administration's proposal, includes State Medicaid systems), with one contractor chosen per region.

Beneficiaries would pay a monthly premium of \$24 per month in 2002, rising to \$44 per month in 2008. Under the program, Medicare would pay 50 percent of enrollees' drug costs, capping the government's contribution at \$1,000 in 2002 (\$2,000 in drug costs) and

increasing to a cap of \$2,500 in 2008. After reaching the cap, beneficiaries would receive no further government assistance, but HCFA by law would require that government contractors sell drugs to the beneficiary at prices HCFA and the contractors agreed on for coverage. Beneficiaries below 135 percent of poverty would pay neither premiums nor cost-sharing, and beneficiaries between 135 and 150 percent of poverty would receive assistance with their premiums on a sliding scale.

As initially outlined, this proposal does not embrace comprehensive reform. It simply adds a burden to the current price-administered, antiquated system, without taking steps to make the system more viable.

Consumer choice also disappears under the Administration's current plan. With a single geographic provider, dissatisfied Medicare beneficiaries have no other options. They cannot shop for a PBM with a different formulary or one that offers better care. Furthermore, because there is no competition, benefit managers have little incentive to respond to customer complaints or make decisions based upon anything but cost.

As an approach to insurance, this plan is upside down. Ironically, it will help seniors with modest, predictable expenses while leaving them vulnerable to large, unexpected costs.

In addition, the proposed benefits are seriously limited. Not only is the benefit capped at \$2000, the protection it provides is weak. Under the Administration's proposal, a senior whose annual drug costs are \$600 would receive a \$12 benefit. The senior will pay \$288 in premiums and be required to pay one-half of the drug costs in coinsurance. So \$600 worth of drugs will cost \$588 -- an expensive way to get a \$12 benefit. For those with drug costs of less than \$600, the benefit begins to make seniors worse off. For example, for \$200 worth of drugs, a senior will pay \$288 in premiums and \$100 in coinsurance. So \$200 worth of drugs will cost \$388, a \$188 added cost. By 2008, a senior with annual drug costs of \$1,000 will pay \$1,028 -- \$528 in premiums plus \$500 coinsurance.

The Clinton plan sets up a monopoly purchasing system, which will quickly translate into price controls on pharmaceuticals.

As the Progressive Policy Institute, a centrist Democratic think tank noted, "price controls...have four key problems: [they] perpetuate the fallacy that bureaucrats and legislators can allocate resources better than consumers and providers in the marketplace; [they] would discourage the development of drugs and biotechnology products for older and disabled Americans; [they] would undermine competition by substituting federally mandated discounts for the hard work of negotiating prices that regularly occurs in the marketplace; and price controls on drugs for seniors would be difficult to implement so that they in fact lower prices for seniors."

Market-based health care reforms like the competitive premium system model would ensure that more people enjoy the benefits of strong competition in the pharmaceutical industry and that we have the resources necessary to continue researching and developing a constant stream of innovative new medicines.

The Administration states that it did not intend to propose a system of price controls. However, we believe that price controls are the inevitable outcome of the Administration's current proposal. We urge the Congress to ensure that any legislation sent to the President's desk does not include or lead to price controls.

Finally, there is no real competition here. There is no "competitive, market-based approach" if the individual beneficiary does not have a choice among competing plans. And a single government contractor cannot offer beneficiaries "market-based alternatives."

IV. Potential Interim Steps

We believe that comprehensive reform of the Medicare system is the only lasting answer to the shortcomings of the present system. We would be greatly disappointed if this Congress and Administration are unable to enact comprehensive reform.

However, we recognize that Congress may prove able to deal only with an especially urgent subset of the overall Medicare problem; namely, those seniors who are unable to pay for their prescription drugs. No matter what policy changes we favor, we all agree it is intolerable that any elderly Americans go without needed medicines for financial reasons.

As mentioned above, Lilly believes that in any stop-gap approach to Medicare reform the prescription drug benefit must be delivered only through the private sector utilizing market-based principles. Only this approach is consistent with a subsequent transition to a competitive premium system.

In delivering an outpatient prescription drug benefit, there are a limited number of practical options. One option considered by the Commission is to expand Medicaid eligibility. We object to expanding eligibility for Medicaid because that program is based on direct price controls in the form of the Medicaid rebate, best price provisions, and CPI caps. Such a system of price controls is a direct threat to the ability of our industry to invest in the research and development efforts necessary to discover and develop new drugs. Moreover, expanding the Medicaid fee-for-service entitlement would erect a substantial barrier to moving to a competitive premium system based on private competing health plans. The two systems are incompatible.

V. Conclusion

In light of the urgent need for reform, the reinvention of Medicare should be guided by our national experience over the past 35 years. Congress should:

- Pursue a comprehensive solution that addresses seniors' total health care needs.
- Approach health care not according to its various parts, but as an integrated whole which allows us to improve overall quality, communication, and convenience; a system that provides the best results for patients and delivers the best economic value.
- Offer seniors choices of health plans that best fit their particular needs.
- Ensure competition – which fosters innovation and quality. Congress should reject any form of government-imposed price controls which delay and deny care for today's patients and impede innovation for tomorrow's patients. Price controls would derail medical progress and – insidiously – we would never know what miracles we had missed.

The next generation of seniors will live longer and healthier lives, and they can be assured of affordable, effective health care if the Congress succeeds in a comprehensive Medicare overhaul. If the Congress and the Administration decide on a short-term approach, we would be disappointed but still strongly urge that these same principles be followed.

Finally, it is important to note that Medicare reform will pose major challenges and require major changes by our company and our industry. At the same time that we are facing dramatic increases in competition in the laboratory and in the marketplace, we would face immense new pressures from the implementation of Medicare reforms. The Breaux-Frist approach, for example, would allow millions of seniors to join large,

integrated health plans with strong leverage over suppliers – including pharmaceutical companies.

Our challenge will be to maintain and accelerate our pace of innovation while confronting greatly intensified marketplace pressures. We are committed to adapt, adjust, and succeed. In an environment of private sector competition, we will stay focused on our mission of delivering pharmaceutical advances to patients with heart disease... cancer... Alzheimer's...diabetes...and other urgent health problems. At Lilly we will do our part to ensure that America continues to lead a global medical revolution.

Thank you for this opportunity to present our views.

The CHAIRMAN. Ms. Steelman.

STATEMENT OF DEBORAH STEELMAN, PRESIDENT, STEELMAN HEALTH STRATEGIES, WASHINGTON, DC.

Ms. STEELMAN. Thank you very much, Mr. Chairman. While I recognize that I was invited as a former commission member of the Medicare Commission which produced the recommendation under pinning Breaux-Frist I would like to speak this morning from the perspective of a mother of two 5-year-olds and the daughter of two septuagenarians.

As such, I have the same desires I think most other Americans do, which is for all seniors to have drug coverage, to have my children not unfairly bear the burden of it, and to have baby-boomers step up to the responsibilities of both financing their retirement programs and improving their facility. This means a Medicare program in which care is not denied improperly, the funding is adequate for benefits, and the administration of benefits in a way that is most efficient and most compassionate.

I think this is the goal that most Americans want for the Medicare program. Now, how we go about that obviously is the question. As it relates to drug benefits, clearly we have got to recognize that 65 percent of Americans already have drug coverage. That leaves 13 million-plus seniors without, and those 13 million seniors today, many of them, are making unacceptable choices.

So I would like to add my voice to Dr. Wilensky's in terms of clearly focusing on them first. We need to help those people who need help now, but we also need to take a look at the entire program, as Senators Breaux and Frist have laid out, and address the longer-term needs.

I would like to underscore Senator Bayh's concerns earlier that there doesn't seem to be as much urgency as one would expect here, particularly given the charts that David Walker presented. And in that context, I would like to talk about solvency for a little bit.

Solvency is an inapt word. It cannot be used as it is for Social Security. Solvency in Medicare refers only to whether or not the HI Trust Fund is taking in more payroll taxes than it is paying out in benefits. General revenue, of course, provides 75 percent of the funding of Part B, and Part B is almost half the size of the program. So while Social Security we already have tremendous general revenue contributions to Medicare.

What we need is a new trigger that would create the public discussion and the urgency with which we need to address this program. The provision in the Breaux-Frist bill that suggests Medicare should be considered insolvent when it approaches 40 percent in terms of general revenue funding is a good trigger. In fact, we would exceed that level by 2008, 6 years earlier than the so-called solvency projections of CBO on the HI Trust Fund. That is exactly the kind of public education tool we need.

So in terms of your question, Senator Breaux, what might be a good down payment I would say that the best down payment you could make for reform in this Congress is a definition of solvency that would better inform the American public about the choices we are facing.

I would also like to see the program restructured so that it is more effective for people. Not only do I want to see those people who need help today get help, but I would like to see better options for all of those people who are both covered and uncovered today.

My parents both have drug coverage; it is from the State government. My father was a judge. It is probably likely to be quite good for their lifetimes. But many other people who work for employers who are not as solid as a State government face a question mark: is my employer benefit going to be there when I need it?

And employers, of course, are facing the increasing costs of the drug coverage because those costs are escalating higher than others, mainly due to utilization and improved new products which are really helping people's lives. But we want them to say, gee, what option do I have? How can I help my employees but keep my retiree program costs more stable?

As Dr. Braun already mentioned, Medigap is not as good an option as we would like. It was structured in 1980 and 1990 according to Federal guidelines which Senator Wyden helped write and made a great deal of sense at the time, but today are a little bit antiquated for the marketplace.

So what can we do to improve the options for those people who are currently covered? We have to think about them, and I think there is no better option than Breaux-Frist, which recommends drug coverage be included in an integrated health plan. I certainly would underscore what Mitch said on that.

To me, the basic requirements for restructuring the market are to make sure, No. 1, that we have a pluralistic marketplace. No monopoly is a good thing, whether it is run by 130,000 pages of regulation as Medicare is today or not. Monopoly is a bad thing; it is not likely to encourage innovation or cost efficiency. So I want a pluralistic marketplace.

That marketplace has to be local and has to be locally priced. It doesn't do any good in Iowa to have the Federal Government in Washington determine how much beneficiaries are going to pay in Iowa. What we need is Iowans deciding the value of their own health care, just like they do in the commercial marketplace. There is no reason for that sort of price competition not to exist in Medicare. Medicare's price controls from Washington make just as little sense in Iowa as they do in New York, even though New York happens to benefit and Iowa does not.

I would also like elastic products. Any product that is defined today is a dinosaur 2 years from now. Health care is moving just that quickly, for which we should all be thankful. So I want an elastic product. I don't want a product that says, oh, you should have a \$100 deductible and a 10 percent copay. I want a product that will allow me as a consumer, over time, to have some influence. That is why the FEHBP program works because Federal employees have a tremendous influence on the design of the product. This feature is present both in Senator Breaux's legislation and in Senator Wyden's legislation. It is very important.

I would only place one limitation on that elasticity. I think that all plans should be required to offer a comprehensive stop-loss. There is no excuse to leave a senior at risk for the most devastat-

ing expenses, whether that is drug coverage or whether that is comprehensive coverage.

Last, I would simply like to underscore David Walker's comments as to the surplus. In 1969, we had a budget surplus that was .03 percent of our GDP. Today, we have a surplus that is 1.8 percent of our GDP, so maybe we have a little bit more flexibility. But in 1970, we were already deficit-spending the very next year. We have been deficit-spending ever since 1970.

So as a baby-boomer, as somebody who cares about my parents and the next 15 years of their benefits, and then the next 25 years of my benefits, and then my kids paying for all this, because my kids are going to be paying and my parents are going to still be alive, I just don't want to rely on so called surplus funding. That is too flimsy a financial assumption.

It has no experimental basis. And it does nothing to reduce the burden on my children. In fact, the assumption of surplus works to increase their burden because it reduces the incentive for reform. My generation is the wealthiest generation in the history of the world. No previous generation has the capacity to save that we do and we need to be rising to the challenge of the cost of our retirement entitlement. I fully support income relating Medicare benefits. And I recognize that to today's seniors that would be a huge change, and it has to be done slowly.

So in terms of the down payment on reform—I certainly think the creation of a new definition of solvency is imperative, I support the creation of a Board, to administer Medicare+Choice, such that its benefits are stabilized, drug coverage can be offered and prices determined locally.

I believe that we have got to focus on rural areas and the need to get Medicare+Choice plans and other options to rural areas, and I think there are hospital refinancing components to that and there are Medicare+Choice payment reforms to that, and there is also the need to reduce administrative burden and risk levels for plans operating in rural areas. These would be the actions to take this year to make a reality of Breaux-Frist long before I retire, and that is certainly what I hope happens.

Thank you, and I apologize for exceeding my time.

Senator BREAUX. When are you retiring.

Ms. STEELMAN. Whenever I retire at 65, my children will only be 25. That is my worry.

[The prepared statement of Ms. Steelman follows:]

**STATEMENT OF
DEBORAH STEELMAN, ESQ.
BEFORE THE
SENATE AGING COMMITTEE**

Deborah Steelman, Esq.
President
Steelman Health Strategies

February 8, 2000

Medicare is the single most important contribution to seniors' health care ever enacted. Because of Medicare, every senior has basic health insurance. But Medicare has not kept pace with modern medicine and the needs of seniors. The Breaux-Frist proposal would transform Medicare into the program it should be, with choices for outpatient prescription drug coverage and stop-loss protection, without disrupting the coverage seniors and their families now rely upon.

Health care has changed dramatically since Medicare was created. In 1965, long hospital stays and confinements in nursing homes were common. People were either treated in a doctor's office or in the hospital. Today, thanks to medical research, hundreds of breakthrough medicines are available allowing people to live longer and healthier lives, especially seniors. Advances in medical treatments mean that more people can be treated at home or in outpatient settings, and with a combination of services like home care, therapy and drugs.

Yet, as this committee is well aware, Medicare's benefit package has not kept pace with modern medicine or the quality of coverage available to the average working citizen today. For example, coverage for outpatient prescription drugs and a cap on out-of-pocket expenses have been standard features for many years in private health plans, including those sponsored by the federal government as an employer.

To compensate for the anachronistic nature of Medicare's benefit package, the private sector has responded in both the employer and individual insurance markets. Many employers offer retiree benefits that include outpatient prescription drugs. Individual options include comprehensive health plans in the Medicare+Choice program and a supplemental insurance market. Over 12 million seniors obtain "wrap-around" coverage through retiree benefit programs, and another 10 million purchase individual insurance plans.

The federal government's most recent attempt to significantly modify Medicare's benefit package, the Medicare Catastrophic Coverage Act, was repealed ten years ago. Its repeal was due largely to opposition from seniors who had paid for retiree benefits in their working years and found themselves faced with significant premium liabilities under the new law. Since then, the federal focus has been on incremental improvements to

Medicare's benefit package, improving the options for comprehensive coverage through the Medicare+Choice program, and ensuring a comprehensive set of benefits to the poorest seniors through Medicaid.

In the decade since the repeal of the Medicare Catastrophic Coverage Act, many state governments have created special state assistance programs just for pharmaceutical therapy. Currently 16 states offer 19 such programs, covering approximately 935,000 seniors. Income eligibility varies from state to state, ranging from about \$9,000 in Maryland to about \$23,000 in Pennsylvania and New York for individuals.

Nevertheless, too many elderly Americans can't get the medicines they need because they cannot afford the private sector coverage that is available, and their resources are too great to qualify for Medicaid or their own state's assistance program.

The inadequate coverage of the Medicare program forces beneficiaries to piece together coverage from multiple sources. Bob Reischauer, former CBO director and current senior fellow at the Brookings Institution, refers to this piecemeal system of acquiring coverage as the "hybrid system." This system is inherently inefficient.

This inefficiency is more serious than may be apparent upon initial review. The Health Care Financing Administration (HCFA) is often credited with disbursing 98 cents on the dollar in benefits. This two-percent administrative cost would be a great source of pride were it not so penny wise and pound foolish. This year, for example, the agency received significant kudos for reducing waste to a mere \$12.6 billion dollars. This only proves how low our standards are for a program in which the highest standards should be demanded. For example, twelve billion dollars a year would be enough to fund a modest prescription drug benefit.

How did Medicare get to the point where \$12 billion in unaccountable expenditures is considered an improvement? The program's complexity, internal inconsistencies, and multi-layered governance structure provide some clues.

Last year the Mayo Clinic estimated that Medicare contained over 132,000 pages of regulation, manual instruction, fraud and abuse guidelines and other federal directives. How much time and talent is consumed by an

organization as respected and as well run as the Mayo Clinic to comply with this blizzard of paperwork? How do many smaller hospitals and physicians offices keep up? And how much true criminal fraud is invited by a system where the clever can so easily manipulate complexity for their own personal gain?

Taxpayers are not the only ones who pay for the inefficiency of the hybrid system. Beneficiaries pay. The most common complaints from seniors are due to the lack of appropriate coordination of benefits between the federal and private sector components of seniors' three-part benefit package; Part A, Part B, and their supplemental coverage. While one carrier decides it is another carriers' responsibility to pay and that carrier decides it is the other carrier's responsibility to pay, seniors are left with confusion and unpaid bills. Or bills get paid twice and a senior calls their doctor's office or the hotline, reporting it, only to be told the amount is too small to worry about.

Any reform of Medicare that does not take into account the entirety of this "hybrid" system will doom seniors and taxpayers to the higher costs of such inefficiency.

Stan Hinton, a retired newspaper reporter who writes of the practical side of retirement for the Washington Post wrote a common sense list of Medicare improvements he and his wife wanted. He wrote, "We want to feel that if we get ill we can depend on Medicare's contractors to handle our claims quickly, efficiently and without a lot of confusion over what Medicare will pay for . . . We want to stop getting those mysterious 'Explanation of Benefits' notices that don't really explain anything. We want to get a letter from Medicare once a year telling us which contractors are handling our doctors' and hospital claims, where their offices are located and their phone numbers . . . We want Medicare, once it reviews and pays one of our claims, to send it electronically to our Medigap policy company. That would help end some of the payment delays." The list continued.

One of the best ways to reduce the confusion is to offer seniors the option of a single comprehensive benefit plan. This is also the best way to provide seniors the kind of benefits that have become so commonplace for workers all across America. Surely it cannot be too difficult for the Congress and the President to agree that all seniors should have the same kind of health plan choices that they have themselves.

From all sides of the political and academic spectrum, there is agreement on the need for a new model. Before the Medicare Commission, witnesses from Heritage Foundation, the Urban Institute, and a variety of universities urged the adoption of some system based on better pricing and better choices. Bob Reischauer testified that "[He did] not think there is any way to address these deficiencies within the current system and so the question is whether there is some different structure that might address these deficiencies."

This was the conclusion of at least 12 of the 17 members of the National Bipartisan Commission on the Future of Medicare. While only ten of us voted for the Commission's final product, it was not due to lack of the required super-majority consensus on this point. Two of the President's appointees to the commission, Laura Tyson and Stuart Altman, said in the Washington Post on March 29, 1999 "We have long supported the idea of market competition to encourage efficiency in health care, so we are sympathetic to the premium support approach."

Why would a super-majority of the Medicare Commission – 8 Republicans and 4 Democrats – and a host of witnesses across the political spectrum all embrace market competition as the direction in which Medicare must turn? I believe it is because the lessons of price controls have been well learned in this country and abroad.

We are all familiar with the waiting line and care denial stories that emanate from other countries. A recent poll found that 75% of Canadians, citing declines in service, now believe their health system is in crisis (Washington Post, 12-18-99). The same article described myriad examples of unavailable and postponed treatments. This is the inevitable result of price controls.

The Breaux-Frist proposal adapts the principles embodied in the Federal Employee Health Benefits Program (FEHBP) to the special needs of seniors and disabled beneficiaries, and to the political, policy, and budgetary challenges that accompany any serious attempt to modify the Medicare program.

The FEHBP, a form of premium support, has served millions of employees and retirees for over 30 years. Employees in every region of the country have numerous choices of comprehensive benefit packages, and benefits are routinely updated to reflect continuing advances in medical technology and improvements in quality of care. Plans have an incentive to offer the most attractive options for beneficiaries at a reasonable cost. Beneficiaries routinely pay about 25% of the premium and their employer, the federal government, pays the rest. Perhaps because beneficiaries have a stable partner in paying their premiums, many federal employees and retirees have chosen fee-for-service plans. Seventy percent of enrollees are in BlueCross/BlueShield or other fee-for-service plans. The remaining thirty percent are in HMOs.¹

The question for the Commission was how to preserve the best of Medicare while incorporating the best of FEHBP?

Guarantee Benefits. Federal employee benefits are delivered year in and year out without arbitrary budgeting by Congress or micromanagement by government.

The first priority of Medicare reform must be to increase the confidence level beneficiaries have in the benefits of the program. This is true not only for today's seniors, but also for those who retire over the coming decades. The biggest fear younger generations have for Social Security is that it will not "be there" when they retire. The biggest fear younger generations have with Medicare is the illusion its benefit package is becoming.

The notion that the Medicare entitlement is secure today is just plain wrong. In fact, as AARP's political ads have pointed out for much of the last two decades, the largest threat to the security of Medicare's entitlement is the relentless and relatively arbitrary budgeting reductions routinely taken by Congress and the Administration. While some applaud the latest CBO's forecasted HI Trust Fund surplus, it should be noted that this estimate results

¹ Merlis, Mark (February 1999), "Medicare Restructuring: The FEHBP Model," (report commissioned by the Henry J. Kaiser Family Foundation)

from little more than the program underspending the original Congressional estimates by \$63 billion. HCFA cannot say why this is happening, and has yet to say how many beneficiaries and providers are being harmed.

Medicare's price controls squeeze benefits. How does a Medicare+Choice enrollee feel when they see their benefits diminish or their health plan leave a market because payment is too low? How secure does a beneficiary feel when Medicare will not allow coverage for multiple procedures performed in the same day? How secure does a transplant patient feel when Medicare's coverage for their immunosuppressant drugs runs out?

These problems would be exacerbated by adding drug coverage to the current Medicare program. More and more of our health care dollar will be devoted to prescription medicines. This is a good thing. Outpatient drugs are the least invasive, least dangerous, most convenient way to treat illness. More and more conditions and diseases of the elderly will be eased or cured by prescription drugs. Yet the cost of paying for these medicines entirely by tax collections would put sufficient pressure on the whole program to make the cost containment measures of the '80's and '90's pale by comparison.

There are some who support price controls either as a way of reducing the cost of drug coverage or as a way of reducing costs for seniors who may or may not have drug coverage. We have only to look at recent experience in Medicare to understand the disruptions caused by prices set in Washington. When the HI Trust Fund underspends last year's estimates by \$63 billion, there are consequences.

These are things no federal employee has to worry about. And yet, the FEHBP has a slower growth rate than Medicare over the same time period, by over a full percentage point.

This seems a good lesson to draw upon in terms of making Medicare's benefits more secure, while at the same time making the program more efficient and cost less.

If our priority is to make benefits predictable and stable from year to year, yet flexible enough to improve over time, prices must vary. In the current Medicare+Choice program, the government administers prices; no wonder benefits vary.

As Professors Feldman and Dowd testified before the Medicare Commission, "HCFA [the agency which runs Medicare] never learns the true cost of providing health care in an efficient system." Under the Breaux-Frist plan, in contrast, plans would determine the premiums and plan designs under oversight of The Medicare Board. This encourages plans to offer the most attractive benefit packages at the most affordable rates.

Guarantee Level of Premium Sharing Today seniors pay about 33 percent of their total medical care costs, even though they pay only about 12 percent of their Medicare costs² which is deducted from their Social Security checks as the Part B premium, currently \$45.50 per month. The Breaux-Frist proposal maintains this same share of beneficiary-to-taxpayer premium sharing.

Like the FEHBP, the federal government would guarantee a certain percent of the total plan premium, allowing beneficiaries to pay a lower premium if they choose a less costly plan and pay more if they choose a high option, or more costly plan. As in FEHBP, the premiums for all health plans would be set by the plans in the marketplace. Experience suggests that running the Medicare program this way would save between one and one and one-half percentage points per year.

Beneficiaries are good shoppers, much better than those in Congress and the bureaucracy at HCFA. As Len Nichols of the Urban Institute said at one of the Commission's early hearings, "it is very difficult to get 10,000 prices right in each of 3,000 counties." Government's role is much better suited to consumer protection than price regulation.

The Breaux-Frist proposal focuses the power of government on what it has shown it can do well in FEHBP: overseeing plans, and not micro-managing prices. Seniors should be able to rely on a guaranteed level of benefits and payments, making their benefits secure and their premium obligations predictable and controllable.

² Upon full implementation of the Balanced Budget Act of 1997, in 2002.

Provide Full Choice of Plans and Comprehensive Benefit Packages. In assessing the differing needs of Medicare beneficiaries and employees enrolled in FEHBP plans, one of the biggest differences had to address was the supplemental insurance many seniors already have. Federal employees get all their insurance from one source; Medicare beneficiaries do not.

The Breaux-Frist proposal resolves this difference by requiring all plan sponsors, whether the federal government or private plans, to offer both a standard option plan and a high option plan.

The standard option would cover the same services as provided through Medicare today, allowing seniors to keep their supplemental insurance if they chose. Seniors must have the option of keeping what they have not only in terms of the existing Medicare program, but also the existing supplemental coverage, whether that coverage is employer-sponsored, individually purchased, or available through Medicaid or other state assistance.

The Breaux-Frist proposal requires all plan sponsors to offer a high option plan that would add coverage for outpatient prescription drugs and a cap on out-of-pocket expenses to the current Medicare benefits, and would pay 25% of the additional premium for any senior who elected a comprehensive plan. This would allow all seniors no matter where they live, to comparison shop and to apply any or all of the resources they may have, including employer contributions or state Medicaid or assistance plan funds, to the purchase of a single, comprehensive health plan of their choice. Amazingly, this simple form of health insurance, the comprehensive health plan, has never been an option in Medicare.

Clearly, a high option comprehensive plan will be much less expensive than purchasing the equivalent coverage through the multi-part "hybrid" system of supplemental+A+B+out-of-pocket. In testimony to the Medicare Commission Reischauer stated, "We provide Medicare, or health benefits to the elderly right now in an inefficient way. And . . . they are paying a lot out-of-pocket. By restructuring the program and consolidating the insurance into one insurance rather than into multiple insurances, you can provide at least those same benefits at less cost." This is the reason I

believe the top priority for any reform must be to provide a predictable, reliable, comprehensive benefit package for seniors, no matter where they live or their level of income.

In the area of taxpayer dollars to support the drug benefit, the Breaux-Frist proposal goes a step further than the Medicare Commission report. By paying 25% of the premium associated with drug coverage, their proposal will reduce adverse selection and will appeal to the economic interests of all seniors. By requiring health plans to offer comprehensive coverage, including outpatient prescription drugs, plenty of coverage options will be available. Drug coverage in such integrated plans should cost no more than \$700-900 per year. That is significantly less than the annual median cost of \$2,400 for Medigap plan "J," which includes limited drug coverage. Second, the Breaux-Frist proposal pays the full cost of a comprehensive health plan for all beneficiaries of low and modest means who cannot afford their share of the premium. Third, The Breaux-Frist proposal guarantees today's Medicare benefits at today's taxpayer-beneficiary share of the premium, with the promise of improved efficiency to lower the beneficiaries' premium and the taxpayers' obligation.

Create Room for Innovation. How would beneficiaries gain if the Medicare "reform" locks the new benefit designs in the same concrete sinking the Medicare benefit package today? Health plans must have a certain flexibility to offer new benefits and services that reflect medical advances and quality improvements giving seniors access to the latest medical treatments.

Again, adopting a FEHBP approach makes senses. The federal program allows plans to talk with enrollees and to do the market research to determine what plan design and innovation in coverage is desired. The Office of Personnel Management oversees the process to ensure against excessive premium increases, unfair competition or intentionally risk averse plan designs, allowing benefit offerings that do not exceed a 10% increase in the actuarial value of the standard package

Guarantee Access to High Option Plans Regardless of Ability to Pay. Other differences between federal enrollees and Medicare beneficiaries include the disparity in income levels and health status.

To enable comprehensive coverage through high option plans, the federal government should cover the entire cost of premiums (but not all deductibles and copays) for seniors whose annual incomes are less than \$10,500.

To guarantee access to health plans for people with serious illness and to ensure against intentional risk selection, Medicare health plans must receive payments that differ according to the health care needs of the patient. I believe a system that required health plan participation in reinsurance, or one that isolates the costs of high cost care, would be more effective than a characterization of individuals health status or statistical compilation of plan usage.

Stabilize Medicare Financing. By introducing competition and choice into the Medicare program, we can slow the rate at which the program's costs rise and preserve it for generations to come.

Competition between plans encourages them to offer quality services at an affordable price. And by linking the government's contribution to the average cost plan, the proposal encourages beneficiaries to select more efficient plans, further keeping down costs.

According to the Congressional Budget Office, HCFA and independent sources, the competition and choice inherent in Breaux-Frist can keep costs down and stem the long-term growth rate of the Medicare program. Estimates indicate Medicare's growth rate would decrease from between one and one and one-half percentage points per year.

But even the Breaux-Frist proponents recognize the difficulty of predicting health care costs over the long term, whether in public or private health spending, regardless of what program is in place. No one can predict with certainty how much this reform, or any other, would reduce Medicare's spending.

At the Commission's first meeting, Alan Greenspan cited the impact of technology as just one of the more unpredictable obstacles to long term estimates, saying that he "...could allude to all sorts of forecasts over the most recent generations--one of the largest difficulties is in forecasting the pattern of technology. It is an extremely difficult activity." That is just one reason why "long-term solvency" is not the primary reason to enact reform

today. There are far more important reasons to enact reform than the "exercises in comparative fantasy," as Bruce Vladeck describes all long-term estimates.

Beneficiaries' health and health care are the primary reasons to reform Medicare and to do it now.

New drugs are at the heart of our hope for long and healthy lives. It is unthinkable that there is no comprehensive and predictable way for all seniors to have drug coverage today. Yet we cannot avoid the possibility that including prescription drugs in the benefit package will bring with it costs that would absorb any savings our reform might achieve as well as add additional, and likely, intolerable taxpayer burdens to future generations.

Along with every other parent of children under the age of 30, I care very much about my children and their fate of becoming the taxpayers supporting millions of baby boomer retirees. My children will be 26 the year I retire. They will be in a first or second job; they will be trying to buy their own health care, a first home, paying the costs of raising children. They will not have had a lifetime to build up assets. And there will be fewer of them in relation to us retirees. Their burden will already be great. So I want to reduce the tax burden for them; I want to do all I can to make the shared responsibilities of future taxpayers and future beneficiaries fair.

To ensure that this debate is more open than the one occurring today - creating Part A "solvency" through general fund transfers of one kind or another -- the Breaux-Frist proposal would create a new concept of solvency. Because beneficiary premiums and the payroll tax rate can only be amended by law, and have proved very difficult to modify over time, the only meaningful solvency test is one based on the amount of general revenues required to make up the difference.

In any year in which the general fund contributions are projected to exceed 40% of annual total Medicare program outlays, the Trustees should be required to notify the Congress that the Medicare program is in danger of becoming insolvent. Congress would be required to legislate alternative funding or to increase the level of general revenues dedicated to the program. This new measure of Medicare solvency would clearly illuminate the ratio of relative financing burdens on general revenues, the Hospital

Insurance payroll tax, and the premiums beneficiaries pay, and would require a public dialogue to determine the fairest financing burden between beneficiaries and younger taxpayers.

The Time Is Now. Mr. Chairman, I believe that by the time I retire we will have a system that looks much like the Beaux-Frist plan. It combines the best of the marketplace and government -- innovative and efficient health care, a guaranteed benefits for seniors, and equitable financing obligations for beneficiaries and younger taxpayers, which ensures quality care at a reasonable price.

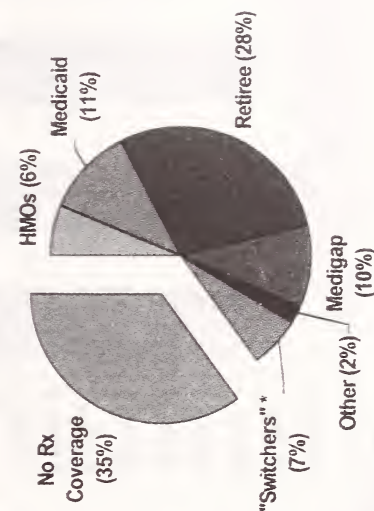
Seniors will never be totally secure about their Medicare program until the Medicare program is taken out of the arbitrary, budget-driven and, bureaucratic process and responds to people's needs more than government's.

ATTACHMENT TO
STATEMENT OF
DEBORAH STEELMAN, ESQ.
BEFORE THE
SENATE AGING COMMITTEE

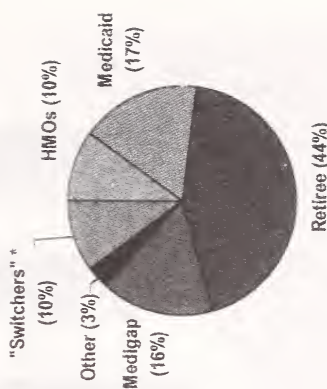
Deborah Steelman, Esq.
President
Steelman Health Strategies

February 8, 2000

65% of Medicare Beneficiaries Have Prescription Drug Coverage



All Medicare Beneficiaries
(Average Annual Rx Expenditure = \$600)



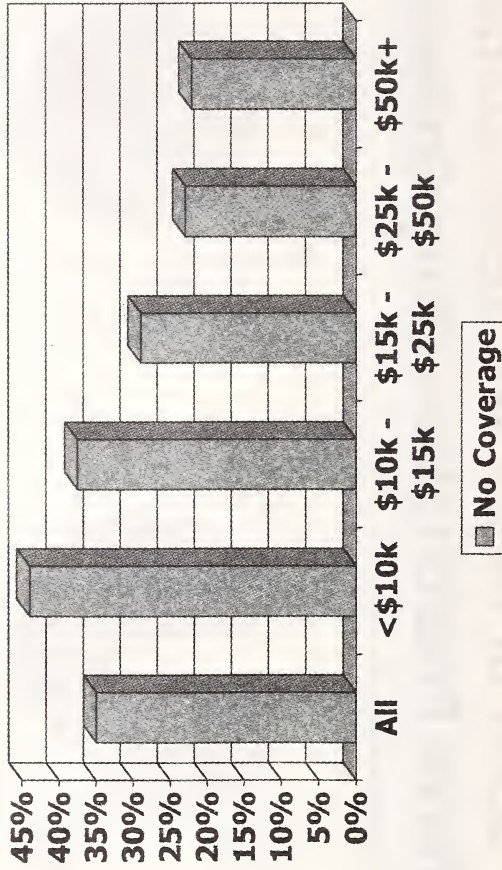
**Medicare Beneficiaries
with Rx Coverage**
(23.9 Million People)

Source: "Prescription Drug Coverage, Utilization and Spending Among Medicare Beneficiaries," Health Affairs, Jan./Feb. 1999, Exhibit #1, p. 235.

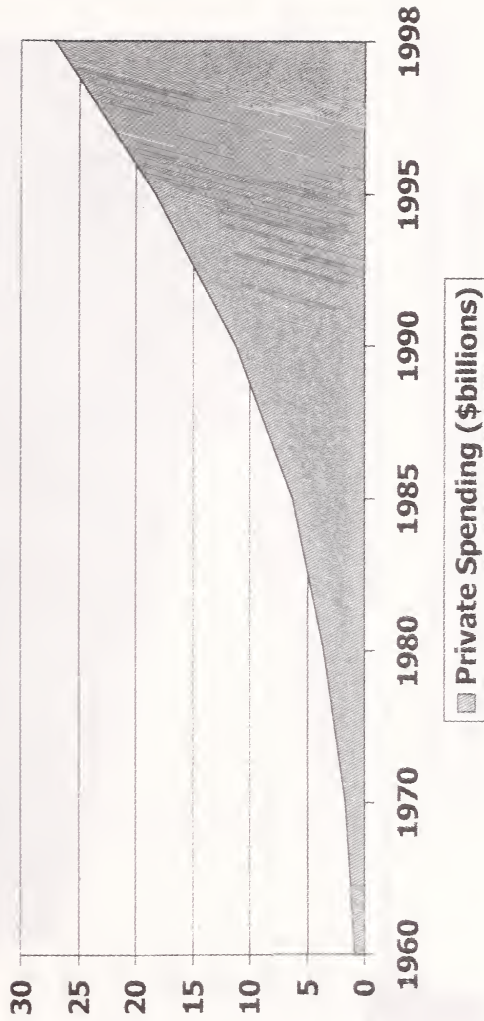
* "Distribution of Noninstitutionalized Medicare Beneficiaries, By Type of Supplemental Insurance and Presence of Drug Coverage, 1995."

* "Those who switched supplementary insurance coverage during the year were placed in a separate category of 'switchers'."

Poorer Beneficiaries Less Likely to Have Drug Coverage

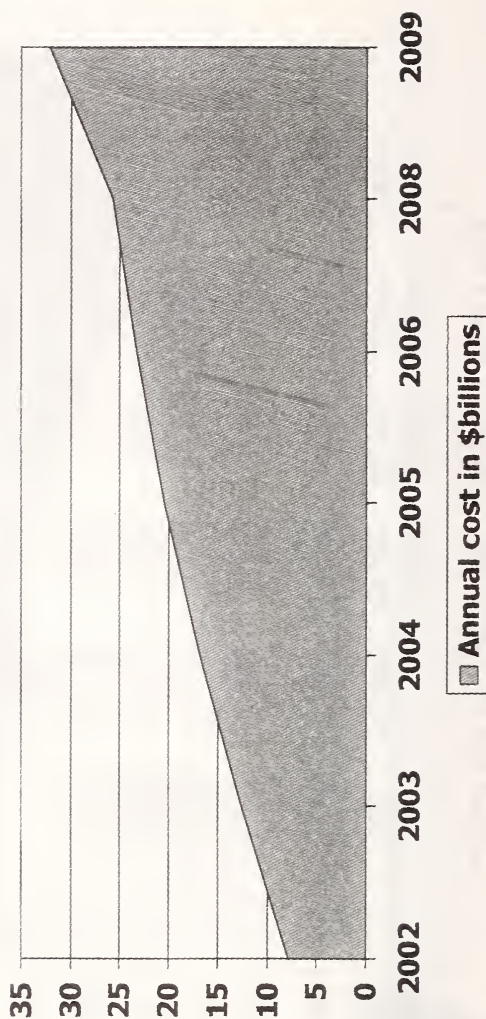


Senior's Rx Spending



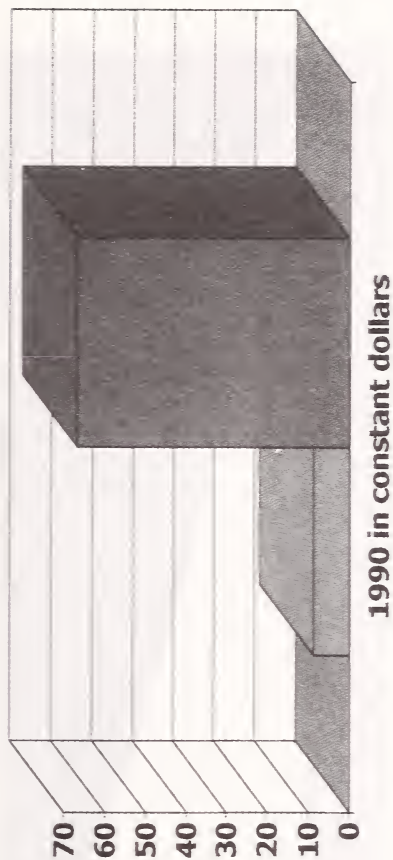
Sources: 1992 - 1996 Medicare Current Beneficiary Surveys and the National Health Expenditures 1998 adjusted for period from 1960 - 1998

The Cost of the Clinton Drug Proposal



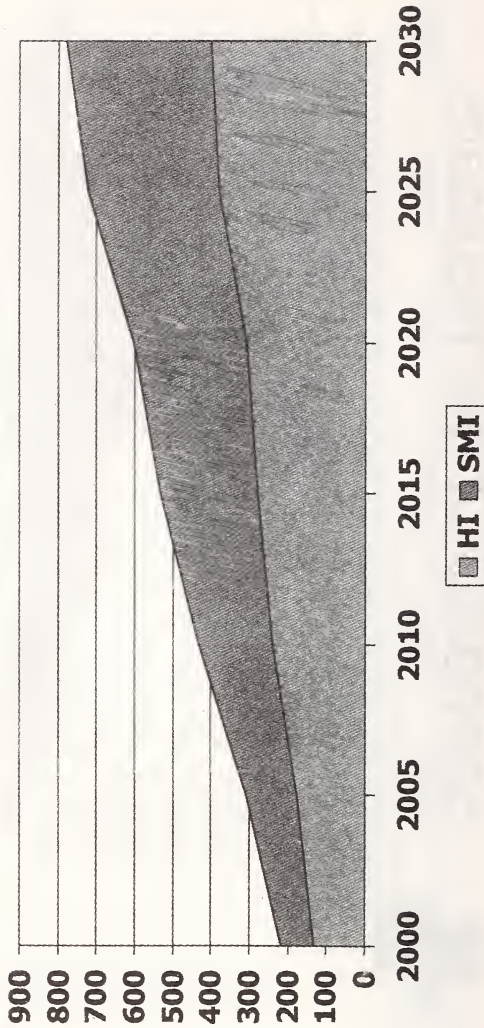
Source: CBO Estimate 1999 -- Table 4

Increase in Senior's Health Care Spending Under Medicare



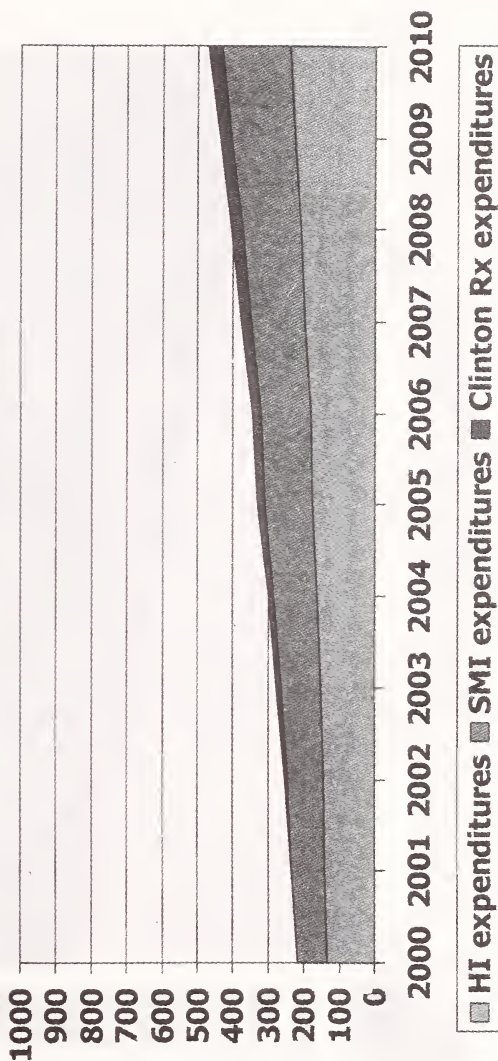
■ Original Medicare HI expenditure Estimate for 1990
■ Actual Medicare HI expenditures for 1990

HI and SMI Spending (\$ in Billions)



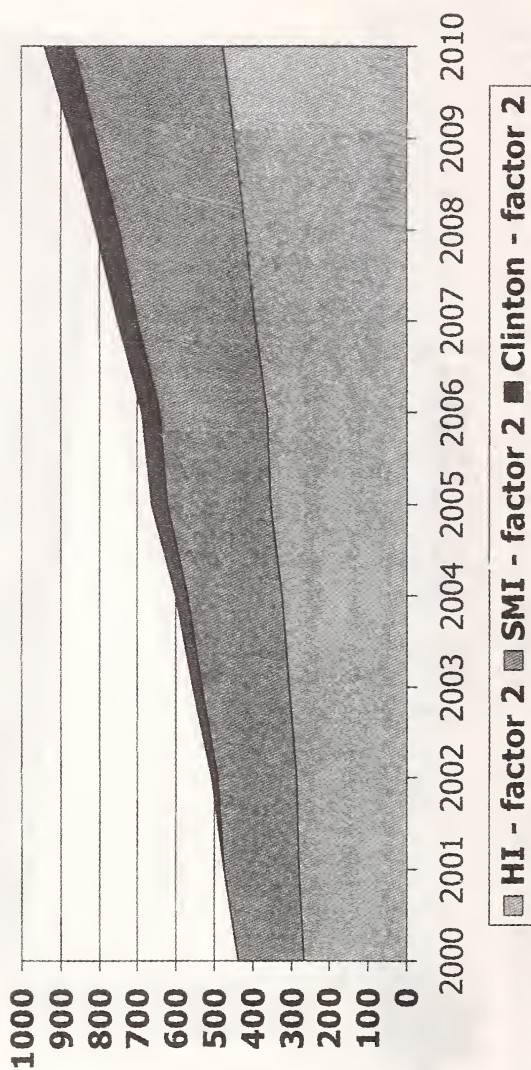
Source: CBO The Budget and Economic Outlook: Fiscal Years 2001-2010 -- 1999 Trustees Report 2015 -- 2030

Medicare Plus Clinton Rx Benefit (in \$billions)



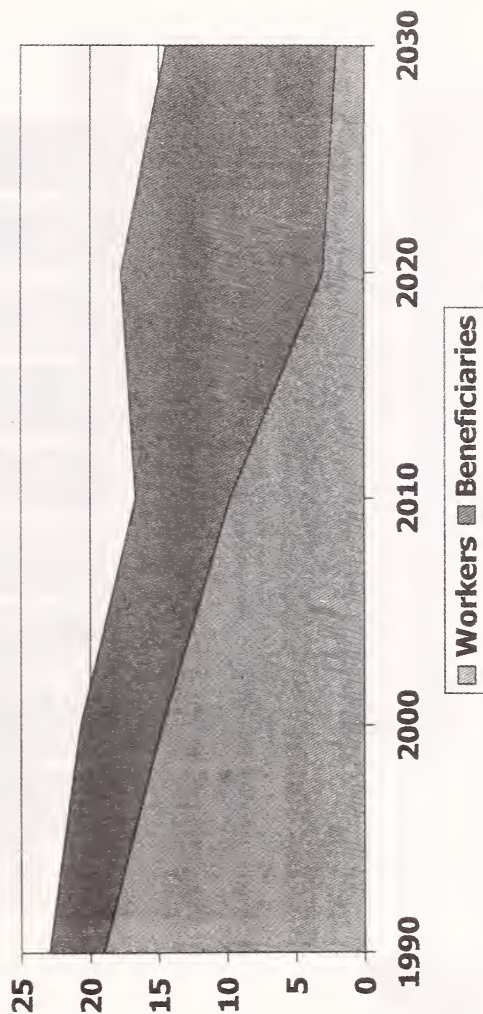
Source: CBO estimates

The Cost of a Medicare Rx Benefit if Estimates Off a Factor of 2



Workers and Medicare Beneficiaries

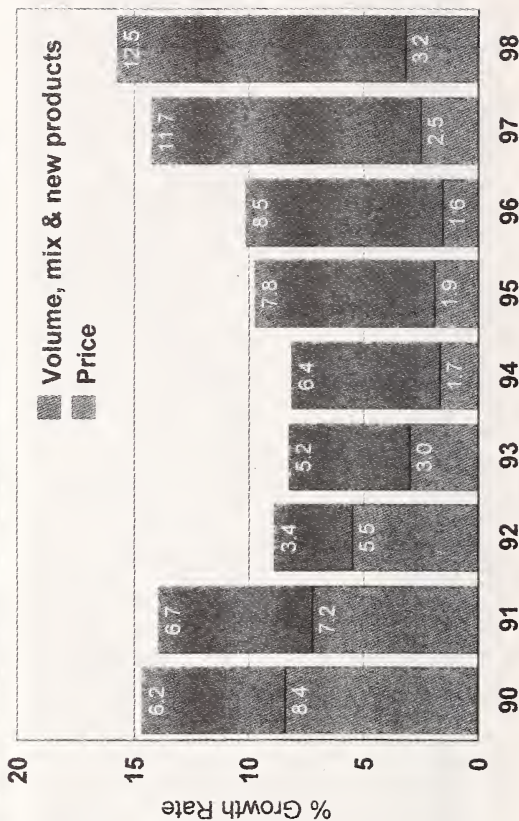
(In millions from prior decade)



Source: 1999 Social Security Trustees Report

Volume, Mix and New Products Account for Increasing Expenditures, **NOT** Prices

Price as a Component of Growth



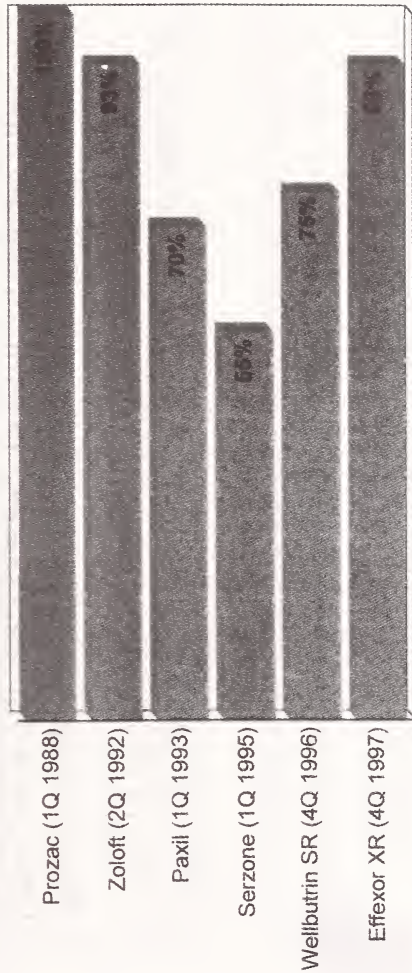
Note: Prior to 1993, market includes only retail pharmacy and nonfederal hospital distribution channels. From 1993 to 1998, market includes six audited channels: retail pharmacies, nonfederal hospitals, staff-model HMOs, long-term care, and federal facilities. Growth rates reflect percent change in sales dollars for specified calendar year versus previous calendar year.

Source: IMS Health, "Retail and Provider Perspective™," 1999; PhRMA Pharmaceutical Industry Profile 1999.

Launch Price Trends

Launch Price as % of Category Leader Price at Time of Launch

Antidepressants



Weighted Average Pharmacy Cost of Daily Therapy
Source: IMS

Displacement Under A Universal, HCFA-Administered Benefit

- CBO Estimates displacement of employer coverage of 25%, or 7.5% of all beneficiaries.
- PricewaterhouseCoopers suggests displacement would be 50-75%, or 6-9m beneficiaries. In terms of dollars, this represents \$3 billion - \$5 billion annually in employer spending being displaced by government spending.

Source: CBO Testimony, Testimony of Dan Crippen, Director of CBO, before the Committee on Finance, U.S. Senate, July 22, 1999.

Source: PricewaterhouseCoopers, "President Clinton's Medicare Prescription Drug Benefit: An Analysis of Displacement of Employer-Sponsored Retiree Prescription Drug Coverage, September 21, 1999.

Canada's Health System, or Any Part of it, Should Not be Imported into the U.S.

Government health system is in crisis...

- Canadians are waiting an average of 43% longer for treatment (i.e., visits to specialists, diagnostic and surgical procedures). In 1997, the average waiting time was 9.3 weeks and in 1998 it jumped to 13.3 weeks.
- An estimated 212,990 Canadians were on hospital waiting lists for surgical procedures in 1998, a 13% increase from 1997.

The Washington Post The New York Times

"From Vancouver to Halifax, the complaint is the same: Not enough hospital beds. Not enough nurses. Not enough doctors. Not enough of the latest equipment that everyone seems to want or need." (WP, 12/18/99)

"In Quebec they've sent more than 250 cancer patients over the border to the United States this year to get treatment and still there are 350 who have waited more than 8 weeks for radiation or chemotherapy (more than 4 weeks is considered medically risky)." (WP, 12/18/99)

"Ms. Boucher, a 58 year old grandmother awaiting open heart surgery [waiting list for open heart surgery is about 5 years], had spent a rough night on a gurney in an emergency room hallway...other hallways of this 3-year old hospital were lined with 66 other patients lying quietly on temporary beds." (NYT, 01/16/00)

"...police officers shot to death a distraught father who had taken a doctor hostage in a Toronto emergency room in an attempt to speed treatment for his sick baby." (NYT, 01/16/00)

"...in Winnipeg, 'hallway medicine' has become so routine that hallway stretcher locations have permanent numbers." (NYT, 01/16/00)

"...local nurses association has launched a program to lure back 6,000 Canadian nurses who, largely out of frustration, have fled to the United States." (WP, 12/18/99)

"So we have the absurdity in Canada that you can get faster care for your gum disease than your cancer, and probably more attentive care for your dog than your grandmother." [Note: Dental and veterinarian care operate in the private sector]. (NYT, 01/16/00)

"A recent poll found that 75% of Canadians, citing declines in service, now believe their health system is in crisis." (WP, 12/18/99)

"Now, Toronto-area hospitals, reflecting legal concerns about lawsuits, ask patients to sign a legal release accepting that while delays in their access to treatment may have jeopardized their health they nevertheless hold the hospital blameless." (WSJ, 01/28/00)

"A survey of teaching hospitals in British Columbia, Washington state, and Oregon revealed that at least 18 surgical and diagnostic procedures readily available in the the U.S. are unavailable in Canada." (WSJ, 01/28/00)

"A National Post article in 1998 claimed that a government study -- not made public -- had catalogued deaths in Quebec resulting from the lack of availability of lifesaving drugs." (WSJ, 01/28/00)

"A 64-year-old patient of mine had serious peptic ulcers controlled for more than five years with a drug called omeprazole. The government required that he be switched to an older, less effective drug. Within three days he required hospitalization and a lifesaving blood transfusion. It took 10 days and several transfusions to stabilize his condition and he was, after huge needless expense, discharged on omeprazole, the drug that he had been on in the first place." (WSJ, 01/28/00)

"Canada's health minister pushed for major reform of the country's ailing state-funded healthcare system on Thursday, saying structural changes were needed to prevent a total collapse." (China Times, 01/31/00)

Many Costs Are Lower in Canada

From Higher Education...

U.S.

Canada

Yale University

(Undergraduate Tuition, Books,
Room and Board)

One Year: \$32,000

...to Fast Food

McDonald's Big Mac

\$2.43

McGill University

(Undergraduate Tuition, Books,
Room and Board, Student Services)

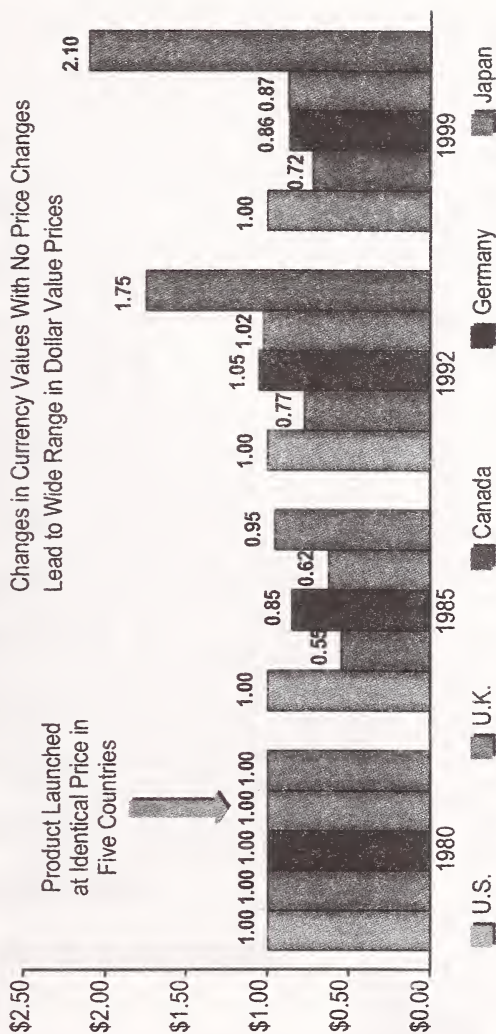
One Year: \$12,566

\$1.98

Source: Published University Data, 2000

Currency Valuation Changes Dramatically Affect International Price Comparisons

Actual Exchange Rates Applied to Hypothetical Product

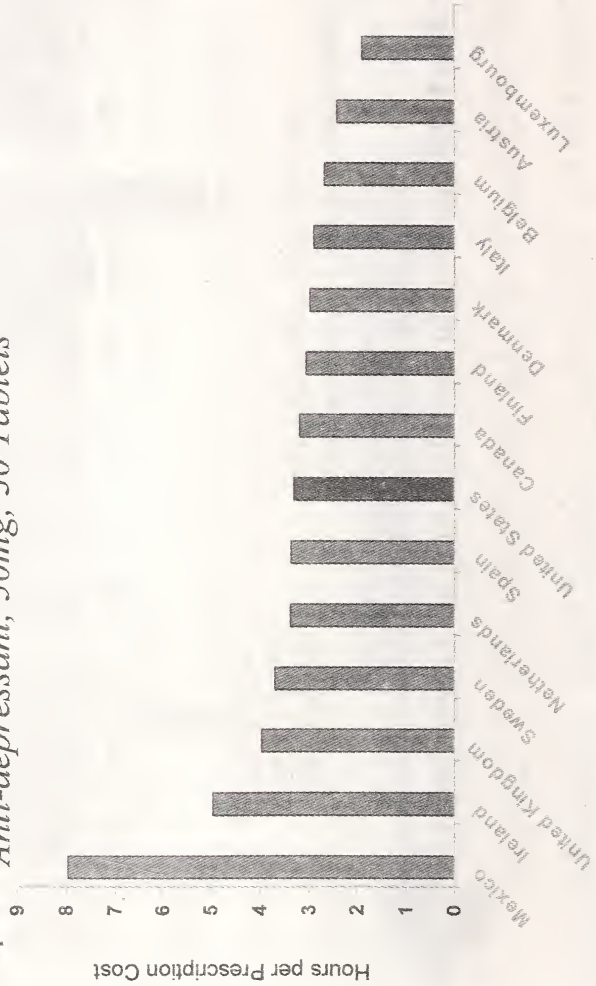


Source: Andersson & McMenamin, Batelle, 1992; Pfizer Analysis of IMF Data

Hours of Work Needed to Buy Medicine

Americans & Canadians Work Almost Same Number of Hours to Purchase Medicines

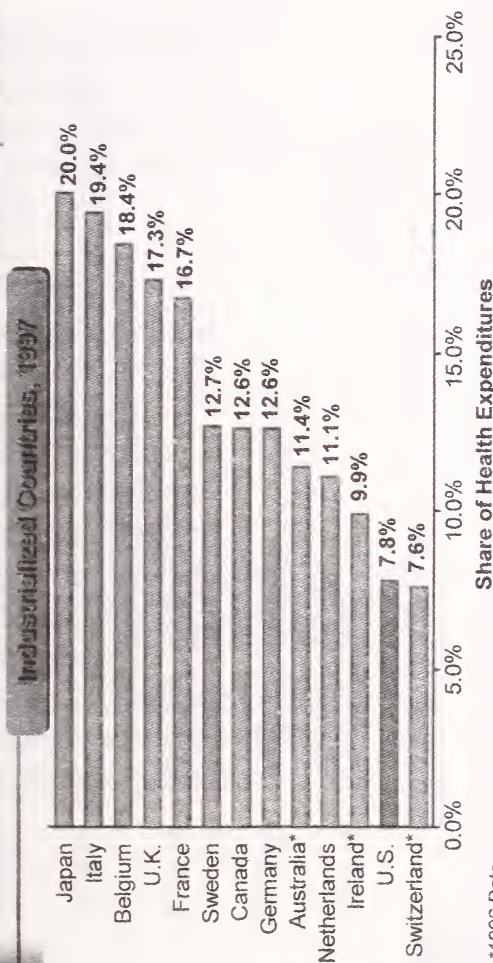
Anti-depressant, 50mg, 30 Tablets



(Implied hourly income is per capita GDP divided by 2000 hours)

Although the U.S. is the World's Largest Pharmaceutical Market, it Spends Less on Pharmaceuticals as a Share of Total Health Care Expenditures Than Most Industrialized Countries

Pharmaceutical Share of Total Healthcare Expenditures



*1996 Data

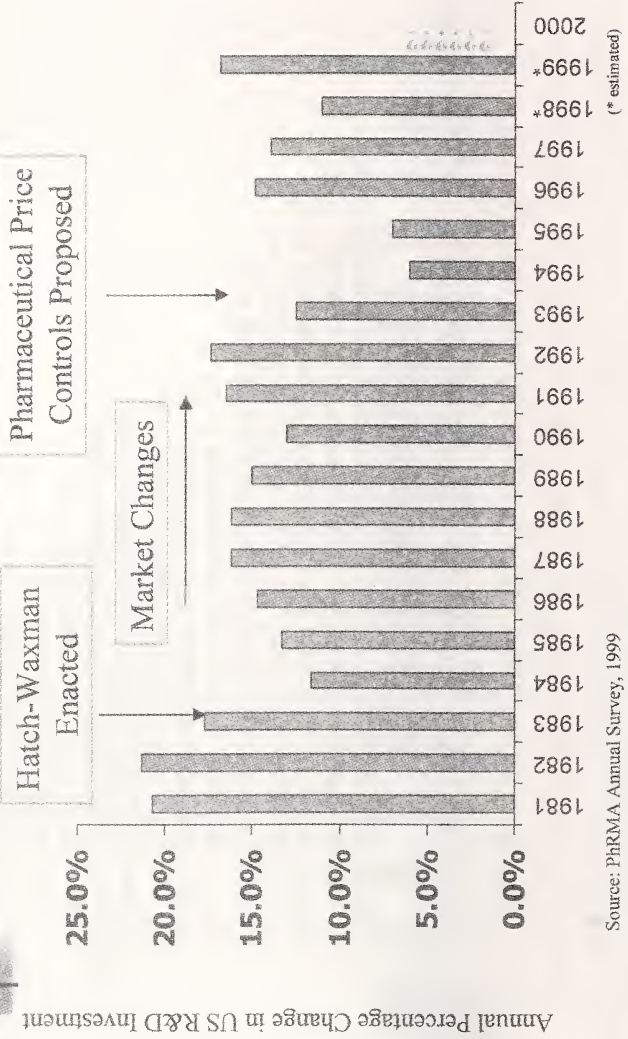
Note: Pharmaceuticals Include Nonprescription Products

Source: OECD Health Data, 1998

■ In the U.S., Pharmaceutical Expenditures as a Percent of National Health Expenditures **Decreased** From 9.0% in 1965 to 7.2% in 1998

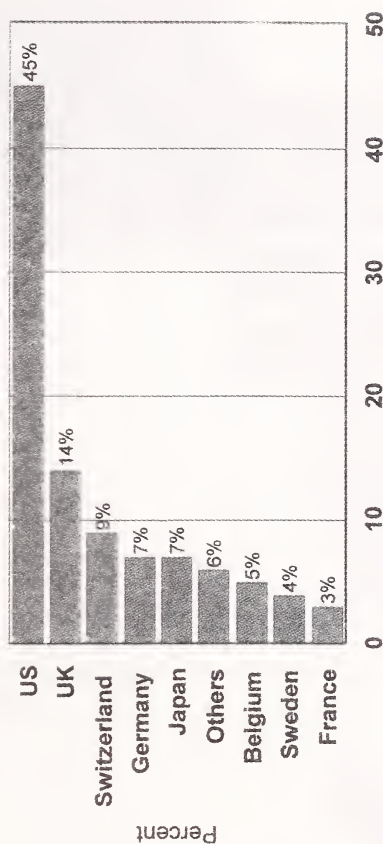
Source: HCFA, 1999

R&D Investment is One Option Among Many for Pharmaceutical Companies: Non-Scientific Forces Have Influence



The U.S. Develops the Majority of Global Drugs

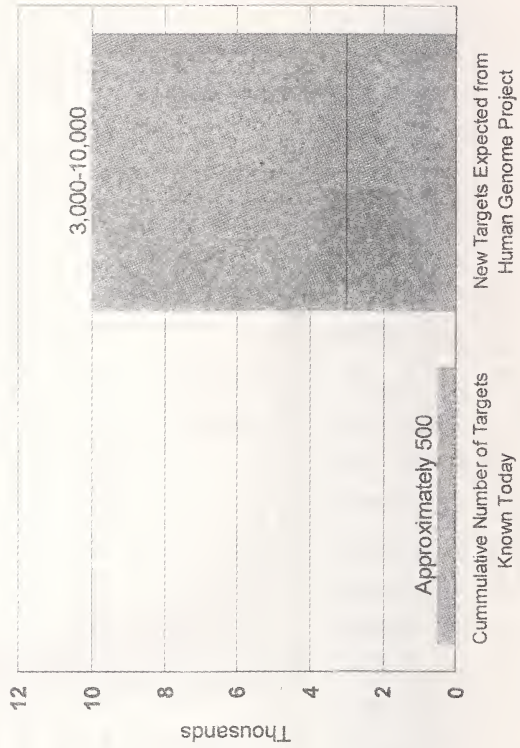
Development of 152 Global Drugs by Country of Origin, 1975-1994



Percent Share of Global* Drugs
*Global drugs: Launched in US, Japan, France, Germany,
UK, Italy & Switzerland

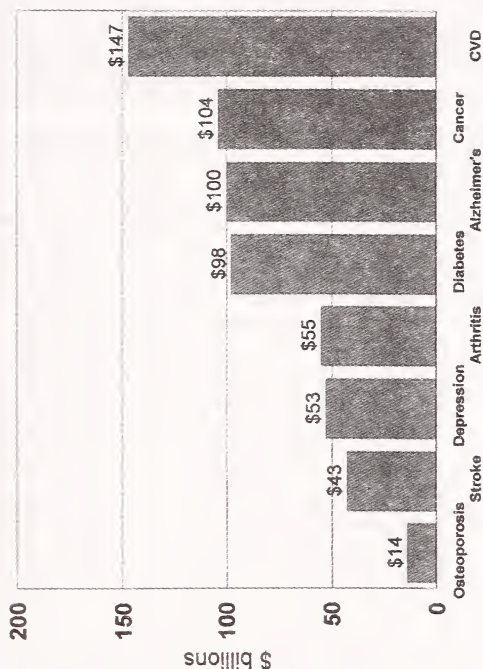
Source: Barral PE. 20 years of pharmaceutical research results throughout the world.
Rhône-Poulenc Rorer Foundation, 1996; PHARMA Industry Profile, 1998.

Impact of Human Genome Project



Source: Drevs J. Genomic sciences and the medicine of tomorrow: commentary on drug development. Nature Biotechnology. 1996;(14).

Estimated Annual Economic Cost of Major Uncured Diseases 1999 (Over \$600b for 8 Diseases)



Source: Pharmaceutical Industry Profile, PhIRMA, 1999

The CHAIRMAN. I want to thank everybody for their testimony. We will have 5 minutes for each member to ask questions, probably limited to one round, unless people want to stay on their own afterwards.

I would suggest first to Dr. Braun, then, you seem to indicate in your testimony that you support incremental changes in Medicare. Yet, it seems to me that your approach to the prescription drug benefit is not incremental. I just would like to make sure why there is a distinction between the drug benefit being comprehensive and structural changes to Medicare being incremental from your point of view.

Dr. BRAUN. I think, Mr. Chairman, the drug benefit we think of sort of as being a piece. The drug benefit would be one part of an incremental movement. I think we feel very strongly that that drug benefit needs to extend to all beneficiaries because otherwise you don't have a sufficient risk pool. And also there needs to be some way to make sure that that risk pool is big enough. Otherwise, it is not going to be a viable choice; it is not going to be affordable.

We also realize that when we are talking about middle-income people, in Medicare half of the Medicare population has an income less than \$20,000. And if you take the out-of-pocket costs for Medicare and the prescription drug cost, that is a huge cost. So I don't know where low-income ends and middle-income starts, but the middle-income people are very much impacted by the costs of prescription drugs if they don't have coverage.

It is very inequitable at the present moment that some people have all kinds of coverage for prescription drugs. One of my neighbors even gets back their Part B payment from their previous employer. So they don't have any costs, and they have no copayments on drugs or what not. And then you have, you know, right down the street somebody who has no coverage and has very high drug costs and is middle-income, but the drug costs are very high and they really are having difficulty covering them. So it is very inequitable at the present time.

The CHAIRMAN. Mitch, we all hear a lot from seniors that drugs are too expensive, and they are maybe even more frustrated that they are paying more than people both here and in foreign countries. Can you explain why that is the case?

Mr. DANIELS. Senator, I really welcome any opportunity to clear up a lot of the confusion, misunderstanding, and misinformation in this area. I think we can start by separating price from cost. Price of drugs, sort of in-line prices, have risen around the rate of inflation now for many years. I can tell you that at our company, prices rose below the rate of inflation over the last several years due to competition in the marketplace.

Now, spending on drugs has gone up and the cost of individual drugs has often gone up, and this is generally for good reasons; as was mentioned by earlier panelists, much higher utilization, and most importantly what the experts call intensity, the substitution of new, higher-quality products for what went before. Four-fifths of the increase in drug costs in recent years is attributed to these phenomena and not price.

And why are we so surprised? Today's cars, which tell you where you are anyplace on the globe and talk back to you about every

problem in the engine, cost more than the cars of a few years ago. Today's cell phones, which you can carry anywhere on the globe and be in instant touch with anybody, cost more than the Princess dial tone that sat on the night stand in 1990. So, likewise, the miracles of many modern pharmaceuticals do cost more on a day of therapy basis, but we believe tremendous value is being delivered.

I would also point out that the United States, through I think some wise actions and balancing of interests in the Congress, benefits from the most aggressive generic drug substitution in the world. And that means that drugs, when they reach the end of their patent life, plummet in price often by as much as 90 percent in the first year. So very recent miracles are available for pennies a day within a few years of coming to market. And many of the best drugs of today will be going off patent in the next few years.

Let me try to be concise about international comparisons. First, to clear away a little underbrush, the data can be very misleading here. We try to introduce products at the same price everywhere, and frequently the erosion of foreign currencies makes those products look cheaper in dollar terms very shortly.

I would also observe that it is not at all unusual for products to cost less in foreign countries, depending on market conditions. Big Macs cost a lot less in Canada and Mexico, too, so do movie tickets and a thousand other commodities I could name.

All that said, it is generally true that prescription medications are somewhat less expensive in foreign countries, not every drug, not every country. But this is almost always the result of price control regimes which we confront in these systems elsewhere, price control regimes for which the patients of those countries pay a very frightful price in terms of drugs that come later or don't come at all, research and development which dies and which emigrates to this country.

The CHAIRMAN. I am going to have to submit the rest of my questions for answer in writing, and particularly I had a couple of questions for you, Ms. Steelman, but I will ask you to answer in writing.

Before he asks questions, then, I am going to ask Senator Breaux to finish the meeting for me because I have a meeting I have to go to now. But I want to thank every panelist for their participation, and Senator Breaux and I consider this the first meeting of a lot of dialog on this subject that we would like to have, and encourage, any input from anybody.

But most important, whether this job gets done this year or not, it is going to get done the first year of the next presidency or it won't be done for another 4 years. And so I want, and Senator Breaux wants the momentum to pick up very much on his proposal so that we can make sure that we are in place to take advantage of the mandate from the next election, whatever that might be. But I am sure that with either party, something is going to have to be done about Medicare reform and about prescription drug coverage for seniors.

So I look forward to working with you and with Senator Breaux to keep this momentum going. I have not given up hope that something can be done this year, but in case it does not, then we have something ready for early action next year.

Senator Breaux, thank you.

Senator Breaux [presiding]. Well, I thank the chairman. I appreciate the chairman's comment before he leaves because he is a very senior member of the Senate Finance Committee, which has jurisdiction, and the opportunity certainly exists to do something in that forum and I am very pleased that he has said what he has said.

I also thank the panel very much for their very helpful comments. Dr. Braun, thank you for being with us. I was talking to Senator Wyden, and your comment that AARP is reserving final judgment on the Breaux-Frist plan until further questions about its impact on Medicare beneficiaries and the Medicare program are answered—I was very happy to hear that. I think it was a pretty positive statement because of the very volatile political issues that are involved in the Medicare program. So we certainly plan to keep our dialog going with AARP and the people that you represent and your people here in the Washington office, as well.

I think we all have the same common goal, and that is to make Medicare for the Nation's 40 million seniors as good as it possibly can be, and also one that we can afford to pay for because if we have the greatest program ever put on paper but we go broke and have no money to pay for it, it is not worth very much.

I did want to point out that you had said in your conclusion that if legislation is pushed through too quickly, et cetera, this would be a very serious mistake. But I take it that you think adding the prescription drug program would not be a very serious mistake.

Dr. BRAUN. You mean separately from Medicare reform?

Senator BREAUX. Yes.

Dr. BRAUN. I think AARP has many of the concerns that have been spoken of here today. If that is passed, is it going to make it more difficult to get the total reform, and the concerns of the low-income people who are suffering day to day, and middle-income people, too? So I think that it is one of those "on the one hand and on the other hand." I would like to thank you, though, for all that you have done on this issue, Senator Breaux. This has moved a great deal since the Medicare Commission, and I think, you know, is really very valuable.

Senator BREAUX. Well, I think you all have been very responsible. I think that we can always differ on some of the paths that we have to take to get to the final destination, but I think that one thing about this particular issue is that everybody has the ability to stop everybody else. And I think that we have to get past that particular position of, well, we will stop you, and then we will stop you as well, and we don't get prescription drugs and we don't get reform.

I mean, we have to come together and do both. We may not be able to do both all at one time, but it is absolutely essential that we have a Medicare program that is on sound financial footing, that is better than it is today, and that one of the ingredients is prescription drugs. And we look forward to working with you.

Dr. BRAUN. Thank you.

Senator BREAUX. Mr. Daniels, running against pharmaceutical companies in today's atmosphere is probably as good as running against communism back in the 1950's because you are a wonderful

target. And I am glad that you are here to talk about this issue, and I think you made some good points.

Open-heart surgery is a lot cheaper in Mexico than it is here. I am not sure too many people would want to run down there and have open-heart surgery. And I have seen some studies that indicate that in Mexico, as an example, the average person who buys drugs in Mexico is a Mexican citizen and pays a larger percent of their disposable income for their prescription drugs than Americans pay for their prescription drugs as a percentage of our income. I think everyone understands, but for the record, we earn more and we pay more. Housing is more expensive here. I can buy cheaper clothes in Mexico than I can here, and the drugs are cheaper as well.

Can you tell me, pharmaceuticals—is it based on the ability to pay by the people you are selling them to?

Mr. DANIELS. First, Senator, let me just state the obvious, which is that we are united in our concern that no American go without pharmaceuticals they need for financial reasons. It is unacceptable, and none of the clarifications that I have or will offer are meant in any way to subtract any momentum from the cause you and your colleagues are leading here.

Yes, the realities in other countries are as you put them. In almost every country, including all the developed countries, a much higher percentage of personal income is devoted to pharmaceuticals. And this is not visible to Americans unless they have lived a portion of their lives elsewhere.

Senator BREAU. If you take an American salary and go to Mexico and buy your drugs, it is a hell of a deal. But if you had a Mexican salary buying the same drugs, it is a lot more difficult.

Mr. DANIELS. That is correct, and I did try to indicate some of the distortions in the data and some of the confusions in the data that sort of cloud the comparisons. But I don't want to obscure the brute reality that in most other countries, governments do dictate at the end of the day the price and, as I mentioned, comes at the great expense of their populations.

The average Canadian waits 15 months longer for new pharmaceuticals while countries and the government argue about the real value. Many times, they are denied that pharmaceutical altogether. And we are finally put in a very difficult position. We either accept and submit to the dictates of these governments and price somewhere down closer to our marginal cost or we disserve our patients who need these therapies and our shareholders for whom we could recover some partial return.

Senator BREAU. So the bottom line is that the billions of dollars that are spent on research by the pharmaceutical industry as an industry is really being paid for by the American consumer because we don't have price controls here in this country. I mean, you were talking about your price increases have been less than inflation, but that is taking out, I guess, the research that also is included in the price.

Mr. DANIELS. Yes. That is simply the price of the product year to year as actually experienced in the marketplace.

Senator BREAU. So what do I say to a constituent who comes up and says, well, look, that is all fine and good as an explanation,

assuming that it is true, and I think it is true, but why should I as an American citizen pay to subsidize the research that is going to benefit someone in Europe who may be much better off than I am?

Mr. DANIELS. The simple answer is if Americans don't pay it, the research will not happen or will be delayed. Cures will be delayed or prevented. There is a legitimate burden-sharing argument here that I think ultimately we have to have, starting perhaps with the developed countries of the world who are riding for free to some extent.

Now, I repeat, they pay a very severe price. Research does not happen in those countries. Twenty-five years ago, France was a research power, probably right up there with the United States, and research has evaporated in that country under price controls. So we do enjoy benefits, but Americans have, I think, a right to question the practices of other countries. And I would forecast that in the future we are moving into, other countries will also confront the questions this committee is leading on and have to modernize their own health care payment system.

Senator BREAU. Ms. Steelman, thank you again for your continuing work in this area. I am going to ask you the same question I asked Gail Wilensky with regard to doing some thinking as to what could we do if we don't—are you going to leave? Let me go ahead and recognize you. I want you to get in here.

Senator BAYH. I apologize.

The CHAIRMAN. No. Go ahead.

Senator BAYH. Just very briefly, Ms. Braun, I would like to thank you for your presence today, and, Debbie, you as well. I heard you mention you have two 5-year-olds, twins?

Ms. STEELMAN. They are 6 months apart. I adopted them in the fall of 1995.

Senator BAYH. Well, the net effect is the same. We have twin 4-year-olds, so I admire all the work you have done in this area while still raising two young ones. That is quite a task.

Mr. Chairman, just two very brief questions. If I could ask Mr. Daniels, the topic of innovation, as I understand it, is really what drives not only better health care outcomes in terms of investment in research for Alzheimer's, heart disease, cancer, and all the other diseases that American citizens are concerned about, but it is also at the heart of the competitiveness of this industry, which is one of the handful that we are really preeminent in on a global basis.

It was something that Senator Breau was touching on that I would like for you to maybe extend a little bit, the relationship between the possibility of price controls and what that might do for the rate of innovation, increased discoveries in terms of cures for some of these diseases, what price controls would do. I am sure there has been some research done in terms of lower dollars for investment in R&D and that kind of thing.

Mr. DANIELS. Well, one can say about five millennia of research, Senator. Price controls would do what they have done throughout history; they would stifle and choke off all incentive, and thereby end or sort of dramatically diminish the activity being controlled. That has been demonstrated over and over and over again as far as I know, without exception.

I would want to say, however, that we don't believe it is the particular business of this committee to worry about the fate of our industry. We are quite proud of its record, and I think all Americans should be. But we are prepared to compete in what we already experience as a more competitive world. If the changes that Breaux-Frist or similar models are offering up for Medicare do happen, we will face a much more competitive environment. Well, that is fair enough. In our business, companies that don't innovate will fall by the wayside, and we will take our chances that we can be one of the exceptions.

Senator BAYH. My last question would be, as I understand your comments, the concern is about the slippery slope, the sort of camel's nose under the tent of price controls by, I think you said baby steps that perhaps in today's environment might appear to be benign, but in the long run could have real adverse consequences.

I think in terms of particularly if we were living in a different—and my question to the previous panel was about not repealing the laws of economic cycles. At some point in our history, we are going to have another downturn in the economy, and the pressure on those of us who set budgets becomes pretty intense, I think, as you are well aware. There is not much appetite for raising taxes, certainly; not much appetite for cutting spending. Well, where do you look, then?

Well, you tend to look at the private sector and take the costs out of that, which then affects the research and the investment in innovation again. So as I understood it, your concerns were really about the long-term implications of some of the proposals that have been floated and where they might ultimately lead in an environment that is different than today, but one that we must surely face eventually.

Mr. DANIELS. That is quite correct. I think price controls at any time are short-sighted and counter-productive, but especially probably in a difficult environment that sooner or later we may face.

Senator BAYH. I would like to thank the panel again, Senator Breaux, and for your leadership as well.

Senator BREAUX. Senator Wyden.

Senator WYDEN. Thank you, Mr. Chairman.

An excellent panel, and let me begin by asking about this. At the end of January, the swords came down. There were advertisements on the air saying if Government gets involved here, Western civilization is going to end. And the President, it seems to me, at the State of the Union deserves a lot of credit by making it clear that this is an urgent matter. He wants to see it addressed, but he left open the particulars with respect to how the bill ought to be dealt with.

I think it is very clear now there is a window to bring people together and to get this done. I hope the window stays open a while, certainly at least a couple of months, but you never know. The question is really how to proceed from here. Of course, Ms. Steelman and the good people at AARP have been through a lot of these battles before.

Senator Snowe and I have the advantage of getting, in effect, the first bite at the apple because we are going to be on the Budget Committee and we are going to try and get a budget resolution

through that will be bipartisan, that will give the freedom to the Finance Committee and the various stages of this sausage-making exercise the chance to do this in a bipartisan kind of way.

I think perhaps I will ask you, Dr. Braun, and you, Ms. Steelman—and I am not leaving you out, Mr. Daniels, for any other reason other than these two have been through a lot of these battles in Washington. Given the fact that we want to take advantage of this opportunity when the swords are down and trying to bring people together, and that we have got this budget resolution where we are going to mark up the first steps of trying to do this in a bipartisan way, what would AARP like to see in terms of these first steps? And then, Ms. Steelman, what would you like to see as we try to get this out of the chute, taking advantage of what is a window that is open now but may not be open forever?

Dr. Braun.

Dr. BRAUN. I think that is very true, and I think it is very important that this be bipartisan and that the administration be involved, also. I think I am not sure I understand, Senator Wyden. Your bill, like the Breaux-Frist bill, the pharmacy part of it, we do have some concerns with, and they are very similar concerns, one of which is it is not a defined benefit under either one, and therefore there could be a good bit of difference between different plans and plans could be designed that will cherry-pick certain populations. And we are very concerned about the whole question of risk pool and costs for some people as against other people.

And I think the other thing is that there is no stop-loss protection for prescription drugs, and I think that is a serious omission in the sense that we have to protect very high-cost drug costs for people. So I think we would like to talk more about that and see what next steps could be done to improve that.

Senator WYDEN. Well, we are happy to do that. Just know that we essentially took the portions of our legislation that mandate universal coverage with ability to pay from your materials, so that there has been a real effort with Marty Corry and all of the good people in your organization to try to do that.

Dr. BRAUN. Yes, I realize that, and I think that is a great plus for both of them that this would be available to everyone. That is a very, very important situation, but that it remain affordable that there be some help for people with very high costs, and so forth, are all questions we are still concerned about.

Senator WYDEN. Ms. Steelman.

Ms. STEELMAN. I would like to see reconciliation instructions written that require the Finance Committee to come up with this new definition of solvency. Last year's reconciliation instructions did include room for long-term Medicare reform as long as they would lead to a solvent HI account. That, as I have said, and all of you know, is irrelevant.

So I think that the Budget Committee which, of course, does deal with the macro, big-picture items—that a new definition of solvency really ought to be tops on your agenda. This is general revenue. How are we going to energize the public to make decisions? So that, to me, would be paramount in terms of reconciliation instructions.

The second thing, I think, is to create the Board and to put in place a process to think through the structural elements and potential consequences of Board administration.

How will the Board's authority differ from HCFA's? It doesn't do any good to create a Board if we simply recreate all the problems we currently have. Senator Wyden we have talked, and one of the concerns I have with your legislation is that the Board reports to the Secretary. To me, what good is that? We already have the Secretary in charge of the Choice program, and we have seen, I do believe, that it doesn't work well. But I believe your Board is an excellent idea if it could be a separate body.

The third thing would be the creation of multiple-choice options. Whether those are precisely what is in Wyden-Snowe or precisely what is in Breaux-Frist, that is an area for argument. That means really tackling Medicare+Choice and the programs underlying problems. That means understanding and addressing the reasons rural areas lack competition. That means tackling the individual insurance market.

Senator WYDEN. Well, you all make thoughtful points. We are open with respect to who the Board reports to. Our legislation SPICE, and SPICE stands for the Senior Prescription Insurance Coverage Equity Act. The SPICE Board is designed to try to ensure accountability without letting HCFA drive the entire system because of the concern of so many colleagues.

Certainly there are some who say that if you don't write it in the way that Senator Snowe and I did, they say who is the Board going to report to? Are they going to report to GE or American Express, since it is no longer a governmental program?

The interesting aspect of your answers, both you, Dr. Braun, and you, Ms. Steelman, is that neither of you offered up in response to that question a target figure in terms of how much money you think it is going to take to get this off the ground.

We were very pleased when the New York Times wrote Sunday very favorably about our legislation. They talked about it costing \$15 billion a year. We think that that is probably in the ball park. I am wondering by way of you all wrapping this up whether you would like to give us your ball park figure of how much it is going to take to run this program in line with the four principles around which I think we can get the President of the United States, Senator Breaux and Senator Frist and Senator Snowe and Senator Wyden to come together on—significant role for private entities, ability to pay, HCFA not in charge of everything, and adequate funding. I would be interested in your thoughts about particularly that last item and what your sense is of what adequate funding might be.

Dr. Braun, do you want to go first, and then we will go to Ms. Steelman?

Dr. BRAUN. I am afraid I am going to have to delay you and suggest you go back to Marty Corry. They have more ideas on finances.

Senator WYDEN. All right, you are spared.

Ms. STEELMAN. I think your 50-percent subsidy for everybody is a little too high, and I don't like the cigarette tax financing because it is not a stable financing source. I do like the 25-percent subsidy

in Breaux-Frist because I think it is enough to give the consumer a great deal and thus alleviate some of the risk selection and participation problems, but doesn't have as great a likelihood of displacing private dollars.

I think my generation should be required to pay more, and providing a lesser subsidy for the drug benefit than for the rest of the Medicare program is a very important way to get more beneficiary participation. And then, of course, I do like both bills and the President's bill in terms of the low-income subsidies. And I will calculate all that up and give you a dollar figure in writing.

Dr. BRAUN. I would like to come back, Senator Wyden, that I think the 50 percent—I would certainly think that AARP would not disagree with the 50-percent subsidy. I think we have some concerns about the 25-percent subsidy, whether or not it actually is going to be high enough to get us a very large risk pool that people will be willing to join.

We have to remember that Part B subsidies just reversed. The beneficiary pays 25 and the general revenue pays 75. So I think the 50-50 for us would seem as if that would be better to get a bigger risk pool.

Senator WYDEN. Well, let me ask for your counsel on both of those points and tell you what it was Senator Snowe and I were thinking about in this area. You know, the Medicare program is spending more than \$12 billion a year picking up the cost of tobacco-related illnesses. So we thought that there was a real connection between a tobacco tax and financing this program.

We recognize there are a lot of members in the U.S. Congress who don't agree with that point of view, and frankly we were pretty amazed to get 54 votes the first time we put it out on the floor of the Congress. The legislation does say that you can use the surplus first. In other words, you don't have to have a tobacco tax. And I am prepared to be sort of like Dustin Hoffman in "Tootsie"; I can be tall or I can be short. And I think there is a good argument for it that I just made, but if my colleagues decide they want to go with just a surplus, that is fine with me.

On the question of the 50-percent issue, we are open as well on that particular point. Our goal was to try to make sure in an understandable way we began to deal with some of the fall-out from the catastrophic care bill. And this is a very hard issue for AARP and the Gray Panthers, where I was director for 7 years before I came to the Congress.

We are putting in place, each one of these bills, a real revolution in terms of ability to pay. That is a transformation of entitlement policy. We are going to say Lee Iacocca is, bless his heart, not going to pay the same rate as the people that John Breaux and I care the most about, which are the people at 135 percent of poverty and in this low-income area.

So there is a lot of agreement, I think, among people who have worked in this area, and if the debate comes down at the end of the day, whether it is 50 percent or 40 percent or the like, we are going to get a bill. We are going to get a bipartisan bill and we would like your counsel for it.

I think it has been a good hearing. You all have been great to be the three to wrap up, and I look forward to working with you.

Senator BREAU. Again, thank you very much for all three of you being with us. I would like to continue to explore, not here but later, the concept of how we put together a package that addresses prescription drugs and addresses reform, recognizing that we may not be able to do all of it this year.

With that, we thank this panel and the other panels, and Senator Frist for his presentation. The committee will be adjourned.

[Whereupon, at 12:35 p.m., the committee was adjourned.]

A P P E N D I X

DEBORAH STEELMAN'S RESPONSES TO SENATOR GRASSLEY'S QUESTIONS

Question. The President just announced an additional \$36 billion dollars to be spent on seniors who have catastrophic drug costs, but the details of how this would be administered do not exist. How do seniors fair under the President's prescription drug proposal versus the Breaux-Frist approach which offers them an actuarial amount worth a minimum of \$800? My understanding is that under the President's plan, which provides a capped benefit and 50 percent coinsurance, the monthly premiums have already gone up from last year, and this plan has not even been enacted yet.

Answer. There are three distinct problems with the President's approach which would not occur under the Breaux-Frist framework. The first problem is the benefit design, it provides first dollar coverage, has a fifty-fifty co-payment, and is capped, thereby exposing beneficiaries to unlimited financial exposure. There is no product like this in the commercial market; people wouldn't buy it. It makes no sense. Medicare's lack of a stop-loss protection is one of the major shortcomings of the current Medicare program, a problem that would be compounded by telling people they would have drug coverage, but still leave them with unlimited financial exposure. The second problem with the President's proposal is the amount of private coverage and private spending that would be displaced by adding a taxpayer-financed Part D benefit. Medicare's draw on taxpayer dollars is already projected to squeeze the generation following the baby boomers; why would we add this burden when so much private coverage already exists? The best coverage available today is from employers; we should not create further incentives for them to curtail or cut back their retiree programs. The third problem is the complete lack of any coordination of benefits. This is one of the principle problems identified by the IOM in its medical errors report, namely the lack of coordination of services results in many medical errors with special reference to those errors that result from inappropriate use of medications. The Breaux-Frist proposal avoids all of these problems by coordinating and integrating the benefit into the health plan and establishing out of pocket limitations.

Question. One of the points you make in your testimony is that the Medicare program is a very confusing patch work of coverage. If we do not include prescription drug coverage as part of reform, but instead handle this issue outside of reform, won't we be adding to this confusion? We will have Part A, B, C and now D. I don't know of any private plans or even other government health care programs that handle coverage this way.

Answer. As you point out in your question, adding a free standing Part D drug benefit will undoubtedly further confuse beneficiaries. Remember that the Medicare program is now composed of three separate parts, Part A, Part B, and Part C, commonly referenced to a Medicare+Choice. But for most beneficiaries, there are also, Medicaid, Medigap, and retiree health benefits to be dealt with. The actual impact of the President's proposal is unclear. For example would employers be incentivized to drop retiree health coverage all together? In the short-term it will absolutely add to the confusion many beneficiaries already face. You are also correct in pointing out that no private plans reflect the multi-part nature of the Medicare program, nor do any of the plans available to Federal employees. One has to wonder why Medicare beneficiaries shouldn't be provided with the same type of health plan choices most Americans and all Federal employees, including Members of Congress and the President enjoy?

DEBORAH STEELMAN'S RESPONSE TO SENATOR JEFFORD'S QUESTION

Question. In your testimony, you describe outpatient drugs as the least invasive, least dangerous, most convenient way to treat illnesses. If this is the case, we

should, in theory, see a reduction in hospital costs as drug expenditures increase. We all know that drugs expenditures has increased dramatically, largely because of increased utilization. Have we seen a corresponding decrease in hospital costs?

Answer. Health care is not a zero sum game. Hospital costs have leveled off, however, innovation may drive up the costs of some types of health care and drive down the costs of other types of health care, but we do not know that exact offsets will be obtained. And we should ask ourselves as a society should we really care? Airplane travel is more costly than when we were still dependent on trains and boats, but enables world wide travel and speed. Health care is the same way: we may increase some costs but life and health are enabled. A hand no longer paralyzed by arthritis is a positive good and highly desired even if it doesn't displace a hospitalization or other cost.

DEBORAH STEELMAN'S RESPONSE TO SENATOR HAGEL'S QUESTION

Question. There is no question that Medicare must be preserved and improved, and that it needs to offer seniors more options and benefits, such as prescription drug, eye, and dental coverage. Like you, I believe that this can only be accomplished by long-term, comprehensive structural reforms that fully address the program's solvency. However, do you believe that the package of reforms proposed by Breaux-Frist should be implemented all at once, or phased in gradually over a period of years?

Answer. These provisions must be phased in. Almost 40 million people rely on Medicare. Their care and security is paramount. But incremental reforms should not be confused with phasing in Breaux-Frist; some short-term "reforms" would significantly retard Congress's ability to move to the kind of Medicare system seniors will benefit most from, one based on full choice of comprehensive benefits packages.

The following incremental reforms would serve to effectively transition today's program to a revitalized Medicare program benefiting millions of seniors:

- a new definition of solvency to enable the public to fully understand Medicare's financial balances and unfunded commitments;
- revamping the Medicare+Choice system to stabilize the payment structure and benefit package;
- providing assistance to low-income seniors who cannot afford the prescription drugs necessary to maintain their health and life; no senior should have to choose between food and drugs.

STEVE GOESER RESPONSES TO SENATOR HAGEL'S QUESTIONS

Question. Although the BBA made payments to Medicare managed care plans more equitable, these payments still vary widely throughout the country. In 2000, Medicare plans in Dade County, FL will receive \$794 per month, nearly twice the \$402 payment received by plans in Lincoln, NE. Under Breaux-Frist, managed care payment rates would no longer be tied to local Medicare fee-for-service spending, but set through competition among plans. In your view, does the Breaux-Frist model provide a more equitable reimbursement formula for Medicare managed care plans, particularly those serving rural communities?

The Breaux-Frist Plan for reforming Medicare calls for premiums set by the national weighted average as well as competition among companies for business in a particular area with geographic and risk factors being applied to the premium. It is our hope that these regional factors would help boost up lower AAPCC areas as compared to the current Medicare fee-for-service spending plans. This does not mean that providers would necessarily be reimbursed more for providing care to Medicare beneficiaries. If there is no competition in a given rural area, then the default plan would be a HCFA-sponsored plan. Without payment reform hospitals and physicians would most likely be paid under the current system which is inadequate at this time.

Question. Under Breaux-Frist's competitive premium support model, are geographic adjusters and local Medicare utilization rates still necessary to ensure that rural providers receive equitable reimbursement under Medicare?

Answer. Geographic adjusters and local Medicare utilization rates will still be necessary to insure rural providers received equitable reimbursement because historical Medicare costs have provided very low AAPCC's in these areas that have resulted in very little managed care activity. If the proposed Medicare commission would set a premium rate for these low areas that would encourage competition among plans, rural seniors may have more choices than they currently have.

STEVE GOESER RESPONSE TO SENATOR COLLINS QUESTIONS

Question. Your description of the Medicare program in Iowa sounds very much like the Medicare program in my State of Maine, where providers have similar concerns about disproportionately low Medicare payment rates. In fact, the Maine Hospital Association was here in Washington last week, and their number one concern is the fact that Maine unfailingly ranks either last or next to the last in the nation in terms of their Medicare payment to cost ratio. While hospitals in other states make money on their Medicare patients, the hospitals in Maine have historically lost money. Moreover, the Medicare shortfall in Maine has resulted in cost-shifting, which has driven up the cost of private health insurance premiums, further exacerbating the access and coverage problems we already are experiencing in our State.

Have you had a similar experience in Iowa? Would this situation be any different under the Breaux-Frist bill?

Answer. The experience that you describe in Maine is very similar to the experience in Iowa. As I stated in my testimony, large numbers of Iowa providers lose money from Medicare and must look to other areas for funds to keep them afloat. This does result in some cost shifting, however, because of our high Medicare and Medicaid utilization in some areas there are very few commercial insurance patients to shift costs to. Hospitals in Iowa must find other sources such as tax support or charitable contributions to keep needed programs in place. The Breaux-Frist bill would help alleviate this problem only if it results in payment reform as well to reimburse providers reasonable cost of providing the care to this group of patients.

STEVE GOESER RESPONSE TO SENATOR JEFFORDS QUESTION

Question. In your testimony, you call for "real choices for Medicare beneficiaries living in rural America." As you know, few Medicare+Choice or any other managed care providers have come to or stayed in rural America. How do you see Medicare Reform structuring "real choices" for rural Medicare beneficiaries?

Answer. Any Medicare reform plan must insure that all Americans, regardless of geographic location have adequate choices as well as equitable benefits. You are correct in stating that few Medicare+Choice plans are available in rural areas and this is largely due to the low AAPCC's in these areas. Managed care companies cannot provide care for rural seniors at those levels. Any Medicare reform initiative must prop up these low costs or efficient markets in order to promote competition among plans.

August 10, 1999

Senator William Roth
Chairman
Senate Committee on Finance

Dear Chairman Roth:

The undersigned national pharmacy organizations, representing all pharmacy practitioners as well as all colleges of pharmacy, are pleased to inform the Senate Committee on Finance of our adoption of a policy on Medicare reform proposals.

On the subject of an appropriate Medicare outpatient pharmacy program, we support a program with separate and distinct features:

- Coverage and payment for the prescription drug products; and
- Coverage and payment for pharmacy services including both professional "pharmacist services" and the dispensing or administration of a prescription. "Pharmacists services" include the provision of care to ensure that medications are used appropriately to improve beneficiaries health status and quality of life, and to contain health care costs.

It has been documented that inappropriate use of prescription medications costs more than \$100 billion each year and that pharmacists' services could provide substantial savings in the health care budget and improve the quality of life. Provisions of such services to elderly beneficiaries may include collaboration of pharmacists with physicians, nurses and other health professionals.

Additionally our organizations will oppose measures not incorporating these two provisions.

The undersigned organizations stand ready to assist in helping to assure, if necessary, the development of a viable Medicare outpatient pharmacy program.

National Community Pharmacists Association
American Pharmaceutical Association
American Society of Consultant Pharmacists
American Society of Health-System Pharmacists
American College of Apothecaries
American College of Clinical Pharmacy
American Association of Colleges of Pharmacy
National Council of State Pharmacy Association Executives
Academy of Managed Care Pharmacy

-More-

PHARMACISTS BY PRACTICE SETTING

201,500 TOTAL LICENSED PHARMACIST IN THE UNITED STATES

- 127,000 pharmacists employed in community retail pharmacies
- 50,000 pharmacists employed in hospitals and HMO settings
- 6,500 pharmacists in consulting settings
- 6,000 pharmacists in government agencies, research, etc
- 4,000 pharmacists in industry
- 3,500 pharmacists in academia
- 2,500 pharmacists in mail order
- 2,000 pharmacists in other settings



MEDICAP PHARMACIES, INC.

February 7th, 2000

The Honorable Charles Grassley, Chairman
United States Senate Special Committee on Aging
Washington, D.C. 20500

Dear Chairman Grassley:

On behalf of Medicap Pharmacies, I am writing regarding the hearing that you will be holding in the Senate Aging Committee on Tuesday, February 8th, "The Right Medicine: Examining the Breaux-Frist Prescription for Saving Medicare." Medicap, which is based in Des Moines, is a pharmacy franchise that operates 55 pharmacies in the state of Iowa.

We commend you for focusing on the issue of prescription drug coverage for Medicare beneficiaries. We believe that older Americans should have access to prescription drugs and pharmacy services, which are among the most cost effective medical interventions in the health care system.

We are seriously concerned, however, about the impact of the Breaux-Frist model as we understand it on the quality of care provided to Medicare beneficiaries, as well as its impact on community retail pharmacies. This model may not be the "right medicine" for Medicare, especially as it relates to prescription drug coverage.

We understand that time constraints may not have allowed for a pharmacy representative at this hearing. Community pharmacists will be important providers in delivering a quality, cost effective prescription drug benefit program for Medicare beneficiaries. We urge that you have another hearing at which time you include a panel of pharmacy providers who can discuss the impact of this model on patient care. We also respectfully ask that you consider asking the enclosed questions to the panel that you have assembled on prescription drug coverage.

Finally, we ask that this letter, and the response to these questions be made part of the hearing record. Thank you very much for your concern about the Medicare program and assuring that Medicare beneficiaries have access to prescription drugs and high quality pharmacy services. We look forward to continuing this dialogue with you in the future. Please call on us if we can be of assistance.

Sincerely,

Stephen C. Mullenix, R.Ph.

Vice President, Managed Care and Professional Services

REGENCY WEST 4 • 4700 WESTOWN PARKWAY, SUITE 300 • WEST DES MOINES, IOWA 50266-6730
PHONE (515) 224-8400 • FAX (515) 224-8415

QUESTIONS ON "BREAUX-FRIST" MODEL IMPACT ON MEDICARE BENEFICIARIES AND COMMUNITY PHARMACIES

QUESTION 1

CAPITATED PAYMENT MECHANISMS FOR PHARMACEUTICAL BENEFIT

Background: Under the fee for service component of the Breaux-Frist model, private entities that contract with HCFA to provide the prescription drug benefit, would be at "full financial risk". Our understanding is that these plans would receive capitated payments from HCFA to provide all the prescription drugs that the beneficiary would need.

We are unaware of any private sector models that currently use "fully" capitated payments to provide prescription drug benefits to older Americans. That is because of the inability of the plans to control prescription drug utilization, which is largely driven by the physician and drug manufacturer advertising. Utilization is especially difficult to control in a senior population, which uses more drugs than the under 65-population. Moreover, since the sicker Medicare beneficiaries are expected to remain in the fee for service program, they are likely to have more drug needs, placing further pressure on the "capitated payment".

To reduce costs under these capitated payment mechanisms, plans generally have to reduce or limit drug coverage or increase cost sharing, which hurts beneficiaries, or reduce payments to pharmacists, which hurts pharmacy providers. That is, beneficiaries and pharmacies will be at substantial health and financial risk under this approach. Alternatively, under these plans, drug manufacturers are not at risk, although they are spending significant amounts of money to promote their products to physicians.

QUESTIONS:

- How do you envision the Medicare fee for service prescription drug benefit working under the Breaux-Frist model? Are you aware of any plans that currently use "capitated" payments to prescription drug benefit plans – especially for senior citizens – to provide a pharmaceutical benefit?
- If so, how do these plans manage utilization? What is the potential impact on beneficiaries if the capitated payment is insufficient to cover pharmaceutical costs?

- There is evidence that direct to consumer advertising is responsible, in part, for an explosion in pharmaceutical expenditures. Other than rebates and discounts, how can pharmaceutical manufacturers "share the risk" for driving utilization in these programs?
- Under the capitation model, should the drug manufacturer be held responsible for increased drug utilization beyond a minimum utilization level? If so, how could this be done? If not, why not?

QUESTION 2**MEDICARE BENEFICIAIRY ACCESS TO MEDICATION
THERAPY MANAGEMENT SERVICES**

Background: It is important to assure the appropriate use of pharmaceuticals through medication therapy management services. These include such programs as medication compliance programs, medication management, disease state management, pharmacist counseling, and others.

A recent Institute of Medicine report on building a safer health care system suggested that pharmacies and pharmacists have an enhanced role in assuring the appropriate use of medications.

Just a week ago, GAO said that "increasing the role of community pharmacists in monitoring drug therapy improves patients' compliance" with their medications. Medcap Pharmacies, Inc. has instituted a number of patient care programs that help to improve the use of pharmaceuticals in patients.

However, we are concerned that many private sector entities that would administer a prescription drug benefit under the Breaux-Frist proposal do not cover or pay for these medication therapy management services. In fact, unlike other proposals that we have seen to expand prescription drug coverage, the Breaux-Frist model does not even mention these services as being part of the standard benefits package. This will undoubtedly place Medicare beneficiaries at risk for potential medication-related problems, especially since they take more prescription drugs than the under-65 population.

QUESTION

- How can we be sure that these private sector entities will incorporate and pay for these services in their standard benefits package?

QUESTION 3**PHARMACEUTICAL COST MANAGEMENT MECHANISMS**

Background: Many private-sector health plans – including many Medicare+Choice plans – are reducing or dropping their prescription drug benefits because of the increasing cost of pharmaceuticals. Other plans, like the Federal Employees Health Benefit Program (FEHBP) – upon which Breaux-Frist is modeled – also have experienced double-digit increases in pharmaceutical costs over the last few years.

Pharmaceutical cost containment strategies under the Breaux-Frist plan would essentially rely on private-sector entities to negotiate pharmaceutical price discounts with drug manufacturers, like formularies, mail order, and restricted pharmacy networks. Yet, there is little evidence that private-sector entities have been able to control the explosion in prescription drug expenditures. For example, a recent report from Kaiser Family Foundation on PBMs, found that the average manufacturer rebate per prescription to a PBM was \$0.96 in 1997, down from \$1.04 per prescription in 1996. With an average prescription price of \$38, the rebate from the manufacturer only represents 3 percent savings from the manufacturers.

Moreover, with the consolidation in the pharmaceutical marketplace, there are fewer “competitors” thereby reducing the “competitive forces” in the manufacturers’ marketplace. Because of the difficulty that these plans have in negotiating with drug companies, they turn their attention to reducing pharmacy payment as a way to control their expenditures, even though pharmacies are responsible for only about 20 percent of the program’s expenditures.

Questions

- Given the consolidation in the pharmaceutical industry, are you concerned that the competitive forces upon which Breaux-Frist is relying to control pharmaceutical costs are diminishing?
- How can we be sure that drug manufacturers contribute proportionately to cost containment in these programs?
- Given that there are really no competitors for new breakthrough drugs, how would you envision these private sector entities negotiating prices with the manufacturers of these companies?
- Given the inability of many private sector entities to negotiate substantial discounts with pharmaceutical companies, how can we be sure that private-sector entities do not manage exploding pharmaceutical costs on the backs of beneficiaries and pharmacies?

QUESTION 4**INCENTIVES TO USE MAIL ORDER PRESCRIPTIONS**

Background: Many of the private sector entities that would contract with HCFA or managed care plans to administer the prescription drug benefits under the Breaux-Frist model would likely use economic incentives to steer beneficiaries to use mail order pharmacy services. This is unfair to Medicare beneficiaries who may want to continue to use their community-based pharmacy provider. We also have concerns about the use of mail order to provide prescription services because face-to-face pharmacy interaction is an important component of helping Medicare beneficiaries understand how to take their medications.

Moreover, when the Federal Employees Health Benefits Program waived its mail order copay in 1996, pharmaceutical utilization exploded because there were no incentives for appropriate utilization of prescription drugs. Finally, mail order prescriptions are usually filled out of state, and undermine the economic base of community pharmacies, which are sometimes the only health care provider in a community, such as in rural states like Iowa.

Questions:

- How can we assure that private plans will use appropriate cost sharing mechanisms that will encourage appropriate utilization of pharmaceuticals?
- How can we be sure that private plans will institute copays or other mechanisms that will not force seniors to use mail order prescriptions, or limit the ability to use their local pharmacy?



February 7, 2000

The Honorable Charles Grassley
Chairman, Special Committee on Aging
United States Senate
SD-G31 Senate Dirksen Office Building
Washington, D.C. 20510

Dear Mr. Chairman:

The Senior Citizens League (TSCL) appreciates your efforts to hold a hearing on S. 1895 this early in the legislative year and the opportunity to submit a written statement to the committee containing TSCL's recommendations on a prescription drug benefit for Medicare beneficiaries. In this regard, request the enclosed document be considered for placement in the committee's February 8, 2000, hearing record.

The over 1.5 million members and supporters of TSCL are pleased that your committee is considering legislation that could provide them the security of a Medicare prescription drug benefit.

Thank you for your consideration of this request.

Sincerely,


Michael F. Ouellette
Director of Legislative Affairs

909 N. Washington Street • Suite 300 • Alexandria, Virginia 22314
1-800-333-TSCL • (703) 548-5568 • Fax (703) 684-3258 • e-mail: tscl4@erols.com • Website: www.tscl.org



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Alexandria Chamber of Commerce



STATEMENT

OF

MICHAEL F. OUELLETTE

DIRECTOR OF LEGISLATIVE AFFAIRS

TO THE

SPECIAL COMMITTEE ON AGING

ON

MEDICARE AND A PRESCRIPTION DRUG BENEFIT

UNITED STATES SENATE

SECOND SESSION, 106TH CONGRESS

FEBRUARY 8, 2000

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Alexandria Chamber of Commerce



**MICHAEL F. OUELLETTE
DIRECTOR OF LEGISLATIVE AFFAIRS
TREA SENIOR CITIZENS LEAGUE**

Mr. Michael F. Ouellette currently serves as Director of Legislative Affairs, TREA Senior Citizens League (TSCL). He is a registered Congressional Lobbyist whose responsibilities include a wide range of programs that concern the defense and protection of the earned retirement benefits of older Americans. His particular areas of expertise include all facets of Social Security, Medicare, annual Cost-of-Living Adjustments (COLAs) for the elderly, seniors' housing issues and legislation to protect the U.S. Flag from physical acts of desecration. Mr. Ouellette is a respected lobbyist in Washington, D.C. with a record of over 200 congressional appearances and testimonies.

A retired Army Sergeant Major, Mr. Ouellette served as the Director of Legislative Affairs for the Non Commissioned Officers Association of the USA (NCOA) for more than eight years following twenty-six year military career. During this period, he additionally served as Co-Chairman of The Military Coalition (TMC) from January 1, 1993 until February 11, 1996, and as Co-Director of the National Military and Veterans Alliance (NMVA). He was responsible for a legislative lobbying program that was recognized on the CBS "60 Minutes" television program as being one of the most powerful and influential in Washington, D.C.

Mr. Ouellette's period of military service included numerous assignment within the United States and overseas tours of duty in the Republic of Vietnam, Japan and Germany. He is a graduate of the U.S. Army Sergeants Major Academy (Class #25) and holds an Associates Degree in Applied Science and General Management from El Paso Community College, El Paso, Texas.

An ardent believer in organizational participation and support, he currently maintains active membership status in the Non Commissioned Officers Association (NCOA), American Legion, Veterans of Foreign Wars (VFW), the National Association of Uniformed Services (NAUS), the 4th Infantry Division Association, the NCO Museum Association and the Knights of Columbus. He also serves as President of NCOA's National Defense Foundation.

A native of Flint, Michigan, Mr. Ouellette is married to the former Darlene Marie Sprague from Swartz Creek, Michigan, and currently resides in Waldorf, Maryland.

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DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

The Senior Citizens League does not currently receive, nor has the League ever received, any federal money for grants or contracts. All of the League's activities and services are accomplished completely free of federal funding.

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Senate Special Committee on Aging

TSCL Members in State

Senator Charles E. Grassley (IA), Chairman	22,207
Senator John B. Breaux (LA), Ranking Chairman	16,168
Senator Jim M. Jeffords (VT)	2,688
Senator Larry E. Craig (ID)	7,942
Senator Conrad Burns (MT)	6,712
Senator Richard C. Shelby (AL)	17,390
Senator Rick Santorum (PA)	75,835
Senator Chuck Hagel (NE)	10,250
Senator Susan M. Collins (ME)	6,978
Senator Michael B. Enzi (WY)	2,764
Senator Tim Hutchinson (AR)	12,619
Senator Jim Bunning (KY)	17,108
Senator Harry Reid (NV)	9,718
Senator Herbert H. Kohl (WI)	36,048
Senator Russ Feingold (WI)	36,048
Senator Ron Wyden (OR)	26,120
Senator Jack Reed (RI)	5,240
Senator Richard H. Bryan (NV)	9,718
Senator Blanche L. Lincoln (AR)	12,619
Senator Evan Bayh (IN)	32,537

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 Alexandria Chamber of Commerce

Mr. Chairman, The Senior Citizens League (TSCL) appreciates the opportunity to submit testimony to your committee concerning the provisions of S.1895, a bill to amend the Social Security Act to preserve and improve the Medicare program. TSCL also appreciates and will take the opportunity to offer a number of insights for consideration and make specific recommendations for general application to any Medicare Prescription Drug Benefit passed by Congress that would be both beneficial and accessible by the League's membership.

TSCL is a non profit, issues advocacy organization representing over 1.5 million members and supporters and is dedicated to serving its members by defending and protecting their earned retirement benefits. The League is registered to conduct grassroots fundraising, public education and lobbying activities in nearly every state, and does not solicit nor accept any money from the federal government. As a matter of information, over 330,661 of our members are constituents of members of this committee and are looking for a Medicare Prescription Drug Benefit to be passed by Congress this year.

Although TSCL has formally supported the Administration's Medicare Reform proposal, the League certainly appreciates the efforts of Senators John Breaux (LA) and Bill Frist (TN) to actually be the first to present a proposal in legislation (S. 1895). TSCL is

equally grateful to this committee for the decision to hold a hearing on this critically important issue this early in the legislative year.

PRELUDE

Mr. Chairman, the hardships for seniors caused by the increasing cost of prescription drugs has spurred the Congress to include the issue among the highest legislative goals and objectives to be considered during the 2nd Session of the 106th Congress. Prices for the 50 prescription drugs most often used by seniors rose 6.6 percent in 1998 --- four times faster than the year's 1.6 percent overall inflation rate, according to a recent study. These rising costs are putting medicine out of reach of a growing number of older Americans, particularly the 35 percent of Medicare recipients without prescription drug insurance. Government figures released in July 1999 projected that senior spending on prescription drugs would grow about 11.2 percent annually during 1999 and 2000. Yet industry figures released in September 1999 showed that prescription spending increases for 1999 already exceeded that amount, up 12 percent with four months remaining in 1999. Additionally, many Medicare recipients that belong to Health Maintenance Organization (HMO's) will have to pay three times as much in monthly premiums in 2000 and will find HMO's far less willing to pay for Doctor-prescribed medicines. In sharp reversal of recent trends, no HMO that accepts Medicare patients next year will cover the full cost of a patient's medicine. Sadly, many HMO's across the nation are

dropping seniors who depended on this protection from coverage at an alarming rate. Particularly hit hard are those seniors residing in rural areas. Faced with the situation just described, many seniors are being forced to travel to Canada or Mexico to purchase prescription medicines at affordable rates. Sadly, when forced to choose between paying for medication or food, older Americans have no choice other than to explore any avenue that provides financial relief because they must have both to survive.

THE ADMINISTRATION'S MEDICARE REFORM PROPOSAL

In June 1999, President Clinton introduced a plan that would offer a voluntary prescription drug benefit to all Medicare beneficiaries. There would be no deductible and a 50 percent co-payment. Premiums would start at \$24 per month in 2002, rising gradually to \$44 per month by 2008. The plan would match a beneficiary's drug costs up to \$1,000 in 2002, rising to \$2,500 by 2008. It would also exclude premiums and co-payments for individuals earning less than \$11,000, or couple earning less than \$15,000. The Administration estimated this proposed drug benefit would cost \$118 billion over ten years. The non-partisan Congressional Budget Office (CBO), however, estimated the cost of the program at \$168 billion (\$50 billion more).

TSCL has supported this proposal because it was the first solid effort to address the prescription drug problem being faced by its members and supporters. TSCL does not

believe that the proposal offers older Americans who have earned a government sponsored benefit, the kind of comprehensive and affordable protection plan that one would reasonably expect would be offered to the older Americans whose efforts during their lifetimes have brought this Country to where it is today.

THE PRESCRIPTION DRUG FAIRNESS ACT OF 1999 (S. 731)

Another proposal that TSCL supports and which drew a substantial amount of support last year is S. 731, introduced by Senators Edward Kennedy (MA) and Tim Johnson (SD). The bill would assure Medicare beneficiaries receive the same reduced drug prices that drug manufacturers currently give their favored customers, such as the federal government and large HMOs. Estimates are that the more favored prices would cut drug costs by as much as 40 percent. A senior citizen spending \$150 a month on prescription drugs could save over \$700 annually under the legislation. The appeal of this legislation is the offer of some protection to Medicare prescription drug consumers without huge costs to finance the program. The downside of this proposal is the fear professed by powerful drug lobbies that it creates "price controls" on the industry and would mean less money for research and development, weakening the industry's ability to create new drugs and improve existing ones. Again, TSCL supports this legislation as it will benefit our members. Ultimately though, TSCL believes that the prescription drug costs

situation being faced by older Americans should be solved by the government and not referred to the pharmaceutical industry for resolution.

THE BREAU-X-FRIST BIPARTISAN MEDICARE REFORM BILL (S. 1895)

While TSCL has not to date supported S. 1895, we wish to extend our appreciation to both Senators Breau-x and Frist for their pro-active efforts to act in an expeditious manner by presenting legislation to significantly reduce the burdens of older Americans and to seek wide public debate on what is referred to as a competitive premium system, a reform proposal supported by a majority of the Medicare Commission earlier last year. In keeping with our commitment to support any legislative efforts to improve the lives of older Americans by protecting and defending their earned retirement benefits, TSCL should be eager to support S. 1895, but has not done so yet. This can be attributed directly to the overall confusion produced by the legislation. Understanding that the bill has been crafted by experts, it simply is not readily understandable and is virtually impossible to clearly and succinctly define the bill to our members and supporters so they will be able to understand the impact on their "pocketbooks." The Administration's proposal is understandable as is S. 731 discussed earlier. This committee is urged to consider action to direct the re-crafting of S. 1895 in understandable language so that older Americans, many who have never had access to a prescription drug benefit of any

kind, will be able to understand the bill in order to allow them to make an educated decision.

TSCL'S VISION OF A PRESCRIPTION DRUG BENEFIT

Very simply, TSCL will lend its full support and urge the grassroots efforts of its members and supporters to a proposed Medicare prescription drug benefit with the following characteristics:

Universal: Any benefit that becomes law would be the same for all Medicare-eligible beneficiaries to include an age 62 – 65 and age 55-62 Medicare buy-in options.

Targeted: Provided additional assistance for low-income beneficiaries.

Voluntary: Older Americans participation in a government-sponsored plan would be voluntary and give them the choice of remaining with any current supplemental plan that they currently possess and maintain confidence. Such a condition would generate a need to field a government-sponsored plan that encourages participation by the vast majority of Medicare-beneficiaries.

Affordable: Would require reasonable monthly premiums, cost-sharing or co-pays with an annual likewise reasonable benefit maximum intended to reduce catastrophic out-of-pocket expenses for the most seriously ill beneficiaries.

Responsible: Would discourage irresponsible or over-utilization of the benefit.

Modernizes Medicare: Like other modern insurers, Medicare would use a benefit manager to negotiate lower drug prices.

Partners with the Private Sector: Would provide incentives to employers to develop and retain retiree drug coverage by possibly paying the entire or portion of the retirees' monthly premium.

Understandable: Any plan considered must be clearly understandable by those who make an enrollment decision.

TSCL believes the Administration's proposal meets the majority of the aforementioned preferred characteristics and is one where support is justifiable. However, the League contends that the complexity of S. 1895 is a major shortfall that needs significant improvement.

TSCL is of the opinion that the 50 percent cost-sharing requirement of the Clinton proposal should be changed to a \$10 co-pay per prescription even if other provisions of the plan were increased. A flat-dollar co-pay requirement would make the plan much more understandable and therefore much easier for older Americans to be able to establish or adjust their monthly prescription drug out-of-pocket costs. Therefore, TSCL recommends to this committee that if the Breaux-Frist plan were to be re-crafted to incorporate a recommended \$10 per prescription co-pay, we could support S. 1895 assuming the required monthly premium was affordable. TSCL also encourages this committee to debate this issue in a totally bipartisan manner, understanding that that the important question to be answered is not whether older American need a prescription drug benefit, but rather how fast it can be made available. For far too long our parents, friends and neighbors have needed some kind of Medicare Drug Benefit. Now is the time to put aside partisan politics and make the lives of these deserving Older Americans more comfortable and dignified.

Thank you



National
COMMUNITY
PHARMACISTS
Association

February 3, 2000

The Honorable Charles Grassley
Special Committee on Aging
G-31 Dirksen Senate Office Building
Washington, DC 20510-6400

Re: Medicare Reform Hearing on S.1895 scheduled for February 8, 2000

Ch...
Dear Senator Grassley:

The purpose of this correspondence is to request that our statement on Medicare Reform presented to the Bipartisan Commission as well a related statement from the pharmacy practitioner groups and the colleges of pharmacy be incorporated in the published record of the cited hearing.

Sincerely,

John M. Rector

John M. Rector
Sr. Vice President
Government Affairs
and General Counsel

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Care You Can Trust

**Executive Summary
of the
National Community Pharmacists Association
Presentation
to the
National Bi-Partisan Commission on the Future of Medicare
September 8, 1998**

The National Community Pharmacists Association (NCPA), formerly the National Association of Retail Druggists, represents more than 35,000 independent pharmacies, where over 75,000 pharmacists dispense most of the nation's prescription drugs and related services.

Our members, who consist of owners, managers and employees, function in the market in a variety of forms. They do business as single stores from apothecaries to full line high volume pharmacies; as independent chains; and as franchisees such as NCPA members involved with Medicine Shoppes. Whatever the form of the business entity, however, independent pharmacists are the decision makers for this wide variety of NCPA member companies.

Numerous studies have documented the cost savings of comprehensive community pharmacy services. When properly utilized, community retail pharmacists save the health care system billions of dollars by reducing the need for much more costly medical services, including emergency room visits, hospitalization, and nursing home admissions.

The failure to provide incentives for full pharmacy services leads to unnecessary and inappropriate prescriptions; to uncounseled prescription drug use; and to reduced patient compliance with appropriate drug regimens. In the long run, this devaluation of professional pharmacists services and the adoption by the insurance industry of a "commodity only" approach to pharmacy services has increased total annual health care expenditures by billions and diminished the quality of life for covered consumers and their families. In summary, there is less payment for less care. Consequently, we believe that the Commission should be very skeptical of so called "managed care" which has eliminated payment for professional pharmacy services.

If pharmaceutical products and pharmacy services are to become a basic core benefit under Medicare, it is essential that:

- Medicare beneficiaries have full access to community pharmacy and community pharmacy has full access to the marketplace.
- All pharmacies, irrespective of practice settings, must be able to acquire prescription drugs at the same price, subject only to economies of scale including volume.
- There be established a realistic professional dispensing fee that recognizes the valuable patient care services provided by the nation's community pharmacists.
- Community pharmacists be able to join together to negotiate with Medicare and its intermediaries.
- Medicare beneficiaries are able to receive prescriptions that are compounded by pharmacists to meet their individualized needs.
- Payments be authorized to pharmacists for disease state management on per-encounter basis for such services as smoking cessation, diabetes, arthritis, asthma, lipids, osteoporosis, cardiovascular and coagulation care management when provided by credentialed pharmacists.
- Beneficiaries retain the right to contract with health care providers including pharmacists for products and services not covered by Medicare.

Enclosed is a copy of "The 76 Billion Dollar Question" which documents the value of pharmacist care to assist the Commission in its assessment of our recommendations.

We thank the Commission for the opportunity to provide recommendations aimed at improving the Medicare program.

NCPA Denounces 'Commodity Only' Approach to Pharmacy

Stephen Giroux, chairman of the National Community Pharmacists Association Legislative Affairs Committee, recently denounced the "commodity-only" approach to pharmacy now taken by many so-called managed care plans, saying the method has increased health costs while harming the quality of care patients receive. Giroux made his comments in testimony before the National Bipartisan Commission on the Future of Medicare.

"In the long run, this devaluation of professional pharmacist services and the adoption by the insurance industry of a 'commodity-only' approach to pharmacy services has increased total annual health care expenditures by billions and diminished the quality of life for covered consumers and their families," said Giroux, owner of Middleport Family Health Center in Middleport, N.Y. He testified before the commission in Washington, D.C., on September 8. The hearing aired several times on C-SPAN.

"There is, in short, less payment for less care. Consequently, we believe the commission should be very skeptical of 'managed care' strategies that fail to provide payment for professional pharmacy services," Giroux said.

"The failure to provide incentives for

comprehensive, personalized pharmacy services leads to unnecessary and inappropriate prescriptions, to uncounseled and unmonitored prescription drug use, and to reduced patient compliance with appropriate drug therapy."

Giroux told the commission that numerous studies have documented the substantial cost savings generated by community pharmacy services. "When properly utilized, community pharmacists save the health care system billions of dollars by reducing the need for much more costly medical services, including emergency room visits, hospitalization, and nursing home admissions," he said.

A coalition of community pharmacy groups and state boards of pharmacy has been formed to guarantee that community pharmacists are appropriately trained and credentialed to provide these cost-saving pharmacist care services, noted Giroux to the commission. In June, NCPA, the National Association of Chain Drug Stores, and the National Association of Boards of Pharmacy announced that they had reached consensus on a national model to adopt standards and credential pharmacists in various areas of disease state management.

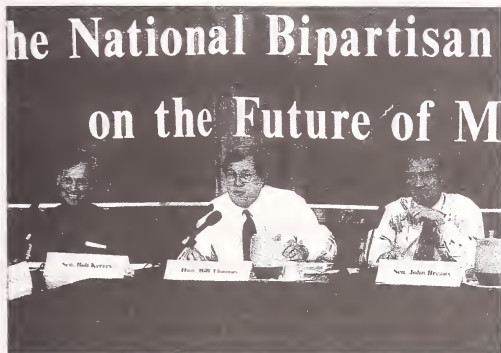
If pharmaceutical products and pharmacy services are to become a core outpatient benefit under Medicare, Giroux said, it is essential that:

- Medicare beneficiaries have full access to community pharmacies and community pharmacies have full access to the marketplace.
- All pharmacies, irrespective of practice setting, be able to acquire prescription drugs at the same price, subject only to economies of scale, including volume.
- A realistic professional dispensing fee be established that recognizes the valuable patient care services provided by the nation's community pharmacists.
- Payments be authorized to pharmacists for disease state management on a per-encounter basis for such services as smoking cessation, diabetes, arthritis, asthma, lipids, osteoporosis, and cardiovascular and coagulation care management when provided by credentialed pharmacists.
- Community pharmacists be able to join together to negotiate with Medicare and its intermediaries.

- Medicare beneficiaries be able to receive prescriptions that are compounded by pharmacists to meet their individualized needs.

- Beneficiaries retain the right to contract with health care providers, including pharmacists for products and services not covered by Medicare.

The National Bipartisan Commission on the Future of Medicare, created by Congress in the Balanced Budget Act of 1997, is charged with examining the Medicare program and making recommendations to strengthen and improve it before the influx of "Baby Boomer" retirees. The 17-member commission, which is meeting with a variety of provider groups in a series of nationally televised encounters, must issue its report to the Congress and the administration by March 1, 1999.



Representing The Profession Well

The nationwide audience for Stephen Giroux's testimony, as broadcast on C-SPAN, captured the attention of one viewer—John D. Rodgers of East Aurora, N.Y. Mr. Rodgers is a pharmacist who is employed by Bristol Myers Squibb in Buffalo, N.Y., and who owns part of an independent community pharmacy in a rural community near that city. Below is his letter to Mr. Giroux.

Dear Stephen,

I was scanning the TV channels for a few minutes... before I had to take my kids to soccer when, to my surprise, whose face do I see on C-Span? Yours! The forum centered around the Medicare Reform debate and you were representing the National Community Pharmacists Association. I watched your entire speech and have to congratulate you on representing the issues and the profession extremely well. I think the points you made were clear, accurate, and best of all, delivered professionally. It is good to see the profession so well represented.

Sincerely, John



Rep. Bill Thomas (R-Calif.) (center) makes a point during hearings held by the National Bipartisan Commission on the Future of Medicare. Sens. Bob Kerry (D-Neb.) (left) and John Breaux (D-La.), fellow commission members, listen.

Stephen Giroux (left) presents his testimony before the National Bipartisan Commission on the Future of Medicare. Giroux, representing NCPA, was the only pharmacist who presented testimony. Sitting to Giroux's left is Sen. John D. Rockefeller (D-Vt.).

Love & Helt For

NCPA and Medicare Pharmacy Debate

The national debate on the scope and direction of Medicare begins in earnest this month when the National Bipartisan Commission on the Future of Medicare is scheduled to issue its report. Our readers will remember that NCPA was the only pharmacy organization to testify before the commission last fall (see *America's Pharmacist*, November 1998).

The subject of Medicare was highlighted in President Clinton's State of the Union Address in January when he called for a Medicare outpatient benefit offering affordable prescription drugs. Several pieces of legislation will be introduced to deal with a drug benefit under Medicare as well as some that deal with the issue outside of Medicare coverage.

NCPA believes—and stated in its testimony to the commission—that the “commodity-only” approach to pharmacy now taken by managed care plans has actually increased health costs, as well as harmed the quality of care patients receive. As we told the commission, “the failure to provide incentives for comprehensive, personalized pharmacy services leads to unnecessary and inappropriate prescriptions, to unmonitored and unmonitored prescription drug use, and to reduced patient compliance with appropriate drug therapy.”

In the coming debate, it is important to affirm again community pharmacy's positions on the issue. If pharmaceutical products and pharmacy services are to become a core outpatient benefit under Medicare, it is essential that:

- Medicare beneficiaries have full

access to community pharmacies and community pharmacies have full access to the marketplace.

- All pharmacies, irrespective of practice setting, be able to acquire prescription drugs at the same price, subject only to economies of scale, including volume.

- A realistic professional dispensing fee be established that recognizes the valuable patient care services provided by the nation's community pharmacists.

- Payments be authorized to pharmacists for disease state management on a per-encounter basis when provided by credentialed pharmacists.

- Community pharmacists be able to join together to negotiate with Medicare and its intermediaries

- Medicare beneficiaries be able to receive prescriptions that are compounded by pharmacists to meet their individualized needs.

- Beneficiaries retain the right to contract with health care providers, including pharmacists for products and services not covered by Medicare.

- A return on investment for the pharmacy.

While the discussion on Medicare outpatient prescription drug coverage is in its beginning stages in this Congress, NCPA has been involved with this issue for several months now. With so many other issues lining up before Congress, it is possible no agreement will be reached this year by legislators on this critical issue. However, you can rest assured that NCPA will be at the forefront of advancing key principles such as those listed above as the debate moves forward.

[illegible]



COMMUNITY RETAIL PHARMACY COALITION



June 29, 1999

The following joint statement is being issued by the leaders of the Community Retail Pharmacy Coalition regarding President Clinton's proposal for a Medicare prescription drug benefit. The statement is attributable to Robert W. Hannan, Interim President of the National Association of Chain Drug Stores, and Calvin J. Anthony, Executive Vice President of the National Community Pharmacists Association.

"The leadership of community pharmacy believes that true marketplace competition has great potential for helping to assure that prescription drugs and professional pharmacy services are available to Medicare beneficiaries at the pharmacy of their choice, regardless of their financial status.

While actual legislation is yet to be developed, we believe that the White House Medicare prescription benefit proposal is a good start towards providing meaningful pharmacy services for all Medicare beneficiaries.

Including community retail pharmacies in plan development and negotiations will help assure that affordable medicines are available to senior Americans and that these beneficiaries will be assisted in their proper use. When prescription drugs are used properly, they can save lives, enhance the quality of life, and reduce medical costs.

We look forward to working with the Administration and Congress to achieve these goals."

The Community Retail Pharmacy Coalition represents the owners and operators of more than 52,000 chain and independent pharmacies with nearly 128,000 community pharmacists who dispensed over 90 percent of the 2.73 billion outpatient prescriptions in 1998.

For more information contact:

Phil Schneider at NACDS at 703-549-3001

Todd Dankmyer at NCPA at 703-683-8200

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National Community Pharmacists Association
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205 Daingerfield Road, Alexandria, Virginia 22314
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RESOLUTION #7

Medicare Reform: One Voice for Practicing Pharmacists

• **WHEREAS**, the Joint Commission of Pharmacy Practitioners (JCPP), under NCPA's leadership, reached a landmark consensus position on a Medicare pharmacy outpatient program; and

• **WHEREAS**, the JCPP organizations, representing practicing pharmacists and the colleges of pharmacy, adopted the following position presented by NCPA on August 10, 1999:

On the subject of an appropriate Medicare outpatient pharmacy program, we support a program with separate and distinct features:

- *Coverage and payment for prescription drug products; and*
- *Coverage and payment for pharmacy services including both professional "pharmacists services" and the dispensing or administration of a prescription. "Pharmacists' services" include the provision of care to ensure that medications are used appropriately to improve beneficiaries' health status and quality of life, and to contain health care costs.*

It has been documented that inappropriate use of prescription medications costs more than \$100 billion each year and that pharmacists' services could provide substantial savings in the health care budget and improve quality of life. Provision of such services to the elderly beneficiaries may include collaboration of pharmacists with physicians, nurses, and other health professionals.

Additionally, our organizations will oppose any measure not incorporating these two provisions:

- **BE IT RESOLVED** that the NCPA, working with all other JCPP organizations, inform each member of Congress and all appropriate congressional staff that unless Medicare reform includes coverage and payment for prescription drug products and for pharmacy services, including both professional "pharmacists' services" and the dispensing or administration of prescriptions, that the

JCPP organizations will oppose any Medicare reform proposal; and

- **BE IT FURTHER RESOLVED** that NCPA encourage practicing pharmacists throughout the country to support this landmark, uniform policy adopted by the following organizations:

- National Community Pharmacists Association
- American Pharmaceutical Association
- American Society of Consultant Pharmacists
- American Society of Health-Systems Pharmacists
- American College of Apothecaries
- American College of Clinical Pharmacy
- American Association of Colleges of Pharmacy
- National Council of State Association Executives
- Academy of Managed Care Pharmacy

Unanimously Approved by the
NCPA House of Delegates
October 27, 1999

Statement on Pharmacy Services for the Elderly

by

National Community Pharmacists Association

NCPA and the 25,000 pharmacy owners, managers, and pharmacists we represent believe a pharmacy benefit to help provide needed medicines for America's seniors is very important. Far too often consumers stand at our pharmacy counters and have to choose whether to buy the prescription or use the money for utilities or other essential living expenses.

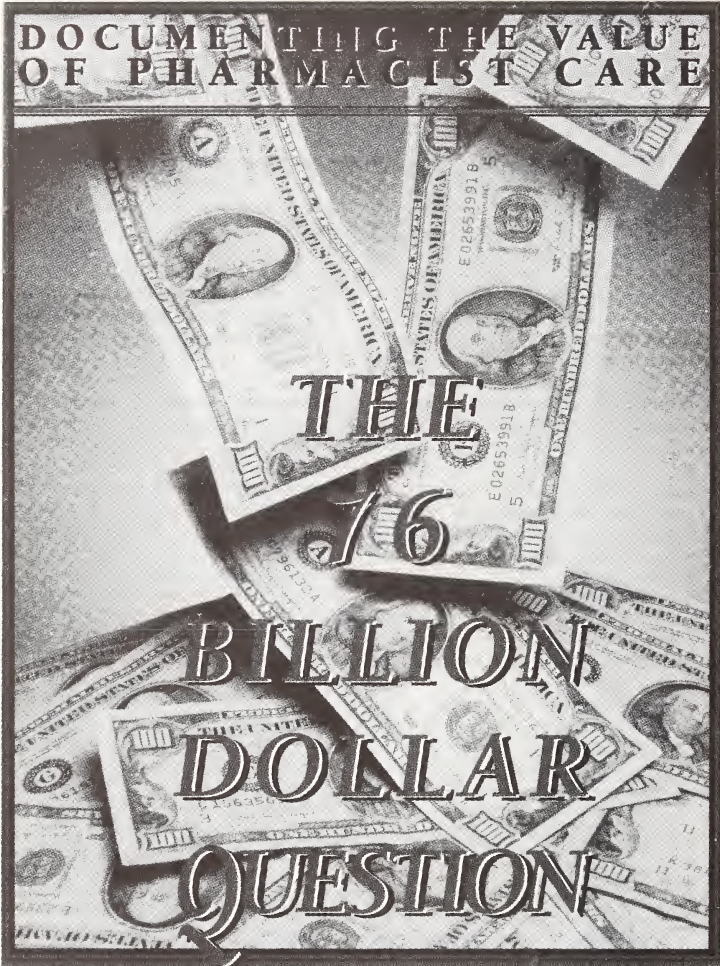
A full blown Medicare reform bill that covers all citizens over the age of 65 is obviously our preference. However, in view of the limited amount of days left in this session and the variety of competing options, it may be that a comprehensive program can not be enacted this year.

If comprehensive reform is not attainable, NCPA believes that an interim measure that is state based, covering lower income seniors, and includes fair payment for pharmacist care services, could be a worthwhile objective.

Calvin J. Anthony, NCPA Executive Vice President and CEO, said "NCFA is pleased to be working hard with APhA, NACDS, and pharmacy practitioners and consumer organizations to help assure that seniors, especially those who are needy, will be able to afford the medicine and services they need.

March 10, 2000

DOCUMENTING THE VALUE
OF PHARMACIST CARE



Research concerning the value of pharmacist care offered
in independent community pharmacies throughout the
United States.

NIPCO

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Alexandria, VA 22314

NCPA Foundation

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Why are American citizens and employers spending \$76 billion a year needlessly?

76 billion dollars. That's how much we spend as a nation on problems caused by not taking medications correctly. Even more than we spend on prescription medication and pharmacy services!¹

Today's health care system demands that patients comply with complicated drug therapy instructions. However, it fails to provide the support and monitoring necessary to help them get well and avoid adverse drug reactions.²

What is the 76 billion dollar answer? The evidence is overwhelming: Pharmacist care can meet this crucial—and expensive—societal challenge.

¹*Managed Healthcare*, June 1994, "Improving Compliance—Solving a \$100 Billion Problem."

²*Pharmacy Today*, October 1995, "Prescription Misuse Costs Billions Annually"

The High Cost of Patients Taking Medications Improperly, Erratically, or Not At All

At least 30% of all patients do not take medications correctly, estimates J. Lyle Bootman, Dean and Professor at the University of Arizona College of Pharmacy. And that percentage rises among the elderly.³

The misuse of medications may involve taking more or less than prescribed. The patient may be confused about instructions. An improvement in symptoms may lead the patient to stop taking the prescription prematurely.

A patient may neglect to have a prescription filled or refilled as directed. Many fail to take medication when scheduled. Many take a drug in combination with food or other medications that cause complications.⁴

The reasons are many, and may be intentional or unintentional. Regardless, the consequences are undeniable. Failing to take medications correctly:⁵

- † Causes an estimated 125,000 deaths every year in the United States for hypertensive patients.
- † Costs 20 million workdays and \$1.5 billion in earnings annually in the United States for heart and circulatory diseases alone.
- † Accounts for 10 percent of all hospital admissions, 25 percent of hospital admissions among the elderly, and 23 percent of all nursing home admissions.

³*Managed Healthcare*, June 1994, "Improving Compliance—Solving a \$100 Billion Problem."

⁴*Family Pharmacist*, undated news release, "Costs and Consequences of Noncompliance."

⁵*Ibid.*

DOCUMENTING THE VALUE OF PHARMACIST CARE /5

The impact is staggering. Modern drug therapy can dramatically improve quality of life and avoid more expensive medical interventions—but only if the patient is properly instructed in medication use.⁶

Studies show that by the time patients get from the physician's office to the pharmacy, they have forgotten half of the doctor's instructions about their prescribed medication. Approximately 10 percent of patients fail to have their prescriptions filled, while 30 percent fail to have their prescriptions refilled.⁷

The consequences of this can be seen dramatically among patients with high blood pressure. As many as 50 percent of blood pressure patients stop taking their medication during the first year. After three years, only a third are still compliant with their prescribed drug regimen.⁸

"I feel so well. It's hard to believe I have high blood pressure," a blood-pressure patient may typically say. Or: "The medicine worked so well, I stopped taking it."

Such reasoning can mean serious medical complications—and expense. A condition that could have been managed with medication instead leads to hospitalization and vastly multiplied costs.

Annually, drug-related problems result in:⁹

- † 8.76 million hospital admissions at a cost of \$47.4 billion
- † 3.15 million admissions to long-term care facilities, costing \$14.4 billion
- † 115 million physician visits at a cost of \$7.5 billion

⁶*Family Pharmacist*, undated news release, "Third-Party Prescription Drug Programs and Pharmacy Services."

⁷*Family Pharmacist*, undated news release, "Costs and Consequences of Noncompliance."

⁸*Ibid.*

⁹*Pharmacy Today*, October 1995, "Prescription Misuse Costs Billions Annually."

Pharmacist Care Offers the Solution to Managing and Monitoring Medication Use

Providing exemplary pharmacy services saves lives, decreases morbidity and lowers health care costs. Many research projects, both in the community and institutional settings, have documented the value of pharmacy services. National surveys have demonstrated repeatedly that the American public has a high level of trust in the community pharmacist.¹⁰

Community pharmacists work closely with patients, physicians and other health care practitioners as members of the health care team. The goal: to manage and monitor medication use and improve therapeutic outcomes.¹¹

The importance of the community pharmacist's position between the drug-distribution and drug-use process cannot be overemphasized.

The pharmacist represents the final point at which medication errors and related problems can be identified and corrected.

As a result, screening prescription orders for problems and intervening when necessary is a central component of the pharmacist's role. With every prescription they dispense, the nation's community pharmacists:¹²

- ✓ Screen the prescription
- ✓ Review the patient profile
- ✓ Correct problems
- ✓ Dispense the medication
- ✓ Counsel the patient
- ✓ Monitor progress

Pharmacists provide a variety of other services:

- ✓ Delivery services and pharmacy 'house calls'
- ✓ 24-hour emergency service
- ✓ Recommendations and counseling on over-the-counter products
- ✓ Health screening and wellness programs
- ✓ Public education

¹⁰Joint Commission of Pharmacy Practitioners, undated news release, "Improving the Quality of Life for Patients and Pharmacy Practitioners."

¹¹Pharmacy Today, October 1995, "Prescription Misuse Costs Billions Annually."

¹²Medical Care, October 1992, "Prescribing Problems and Pharmacist Interventions in Community Practice."

¹³Family Pharmacist, undated news release, "Comprehensive Pharmacy Care."

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*I*ndependent pharmacists are health counselors who know their patients' complete health picture and consult regularly with physicians about the medications they prescribe.

- † 98 percent of independent family pharmacists counsel patients face to face about their prescriptions.
- † In addition to providing face-to-face counseling, 97 percent of independent family pharmacists maintain patient profiles, 87 percent offer free delivery services, and 78 percent offer 24-hour emergency care.
- † Every day, the typical independent family pharmacist talks with physicians 23 times and spends almost two hours counseling patients about their medication and health care needs.
- † More than 75 percent of independent family pharmacists provide home health care pharmacy services, and 74 percent provide home diagnostic equipment and supplies, such as blood glucose monitors for diabetes patients.
- † A recent study found nearly 60 percent of people patronizing independent family pharmacies agreed with the statement: "The pharmacist knows me and my family."¹⁴

Pharmacist care can lower health risks and save millions of dollars annually in direct medical costs, and in the indirect costs of lost wages and reduced productivity.¹⁵

Independent family pharmacists add significant value to a company's prescription benefit plan by providing comprehensive pharmacist care and reducing overall health care costs.¹⁶

Hospital and nursing-home care is extremely expensive. Most compliance-related admissions are avoidable if we make medication compliance a priority.¹⁷ With the aging of the American population, the dimensions of this problem will only get worse—unless we better utilize the excellent resources we already have in family pharmacists.

Every day, the professional judgment of skilled independent family pharmacists saves money, trouble and, most importantly, lives.

¹⁴Family Pharmacist, undated news release, "The Independent Family Pharmacist: A Fact Sheet."

¹⁵Family Pharmacist, undated news release, "NARD Launches Education Campaign Targeting Employers and Consumers."

¹⁶Family Pharmacist, undated news release, "Comprehensive Pharmacy Care."

¹⁷Family Pharmacist, undated news release, "NARD Launches Education Campaign Targeting Employers and Consumers."

Life-Changing Intervention: The Ultimate Value of Pharmacist Care

A newborn saved from liver damage. Patients saved from hemorrhaging due to dangerous drug interactions. A woman who asked for eye drops to treat what turned out to be a detached retina.¹⁸

Such problems present themselves daily to pharmacists, who must then intervene on their patients' behalf to correct the problems. By intervening, pharmacists can save their patients money, trouble and even their lives.

- † A pharmacist in Colorado was asked to dispense a prescription for an anti-fungal medication for a child. The pharmacist, who knew the family well, was amazed to see the prescription was for a newborn. The prescribed dosage was 10 times higher than recommended for a baby. By identifying the error, the pharmacist saved the infant from potential permanent liver damage.
- † In Pennsylvania, a woman came in a pharmacy looking for eye drops. After asking about her symptoms, the pharmacist recommended she see her eye doctor instead. It turned out she had suffered a detached retina.
- † In Wisconsin, a woman came in a pharmacy looking for cough medicine for her husband. After asking about the husband's symptoms, the pharmacist recommended the woman take her husband to a doctor. She did, and that night, her husband was admitted to the hospital for bacterial pneumonia and remained hospitalized for 10 days.
- † In Tennessee, a doctor told the parents of a 10-year-old patient that he was cutting the child's Ritalin dosage in half to alleviate side effects. When the family visited their pharmacist, he talked with them and learned the doctor was cutting the dosage. However, when the pharmacist checked the prescription, he discovered the doctor had out of habit written out the old prescription by mistake. The mistake would not have been discovered if the pharmacist had not talked with the family.

¹⁸Tennessee Pharmacist, August 1993, "Pharmacists' Interventions Save Money, Trouble and Lives."

DOCUMENTING THE VALUE OF PHARMACIST CARE /9

These are not isolated incidents. A recent survey documented more than 1,000 cases of such interventions by pharmacists. Had the patients involved bought their prescriptions from a volume-driven pharmacy such as an unregulated mail-order firm, it is highly unlikely these interventions would have occurred.

Another study of 89 community pharmacists in five states concluded that 28.3 percent of the prescribing problems identified could have caused patient harm if the pharmacist had not intervened to correct the problem.¹⁹

The purpose of the traditional collaboration between physician and pharmacist in the delivery of pharmacist care is to combine the unique knowledge and competencies of each to achieve optimal outcomes in, and for, the patient. Central to the responsibilities that pharmacists maintain in this process is the screening of new prescription orders to ensure that prescribed drug therapy is safe and appropriate.

Central to the responsibilities that pharmacists maintain in this process is the screening of new prescription orders to ensure that prescribed drug therapy is safe and appropriate.

Among the more common problems cited by pharmacists as reasons for intervening, incorrect dosage ranked highest. In 18 percent of the pharmacist interventions involving prescriptions, and 42 percent of those involving over-the-counter medicines, the pharmacist made the professional judgment that the patient should *not* receive the medication.²⁰

- In Pennsylvania, a pharmacist discovered that a man who had been prescribed a high blood pressure medication was also taking other drugs that could produce a dangerous interaction. The pharmacist referred the patient back to his doctor, who disagreed and gave the patient samples of the prescribed blood-pressure medication. The next day, the patient collapsed and had to be hospitalized for five days.
- A California pharmacist discovered that a patient who was already taking a non-steroidal anti-inflammatory drug had been prescribed codeine by a surgeon. The combination of the two drugs could have caused severe gastrointestinal bleeding.
- A family pharmacist in Virginia discovered that one of his patients, using another facility, was given a blood thinner instead of the anti-hypertension medication ordered. The bottle was labeled as the ordered medication, but it contained a powerful blood thinner. Taking the blood thinner could have been lethal, given the patient's medical condition.

Local pharmacists improve their patients' quality of life day-in and day-out by working closely with them.

¹⁹Michael T. Rupp and David H. Kreling, Oct. 1992 paper, "Alternate Payment Methods: Value and Payment of Pharmacy Services."

²⁰Tennessee Pharmacist, August 1993, "Pharmacists' Interventions Save Money, Trouble and Lives."

The Role of Pharmacist Care in Reducing Health Care Costs

The impact of pharmacist care on individuals is clear. However, the driving forces that have been reshaping health care in recent years threaten quality pharmacist care.

Rising health care costs in recent decades have led to more aggressive cost-containment strategies in most public and private health insurance programs. Even though studies have documented the value of the pharmacist as a health care professional, it has grown difficult to obtain adequate compensation from public and private third-party program administrators for providing these services.²¹

With the aging of the population and the development of sophisticated new drugs, pharmacist care has become vitally important in helping people stay healthy. Today, prescription drugs have proven to be an extraordinarily cost-effective alternative to surgery or other more costly and invasive medical interventions.

Although individually some drugs appear to be costly, these drugs when used appropriately are far less expensive than the alternatives of hospitalization, surgery or other sustained medical treatment. New ulcer medications, for example, have saved the United States millions in ulcer surgery, and innovative heart medications are preventing heart attacks and deaths, and reducing the need for heart surgery.²²

Drug therapy is a vastly preferable and economical alternative to hospitalization.

Although drug therapy is cost effective and typically represents a small percentage of overall plan costs, it is a cost component that is growing rapidly, prompting more attention to contain those costs. However, one sure method of cost containment is for patients to take their medications as directed.

The chart below illustrates the rates and possible consequences of medication misuse involving several conditions.²³

TYPE OF MISUSE	CONSEQUENCES
5% of patients	Osteoporosis
20% of patients	Condition worsens
30% of patients	Relapse, hospitalization
40% of patients	Loss of control
45% of patients	Hospitalization
50% of patients	Relapse
60% of patients	Bleeding, hospitalization
70% of patients	Attacks, hospitalization
85% of patients	Rejection, death
90% of patients	Unwanted pregnancy

²¹Family Pharmacist, undated news release, "Third-Party Prescription Drug Programs and Pharmacy Services."

²²Ibid.

²³Managed Healthcare, June 1994, "Improving Compliance—Solving a \$100 Billion Problem."

DOCUMENTING THE VALUE OF PHARMACIST CARE /11

Third-party payers have often targeted pharmacy reimbursement in an effort to contain pharmaceutical costs. A large number of employers are now restricting their beneficiaries' freedom to select the pharmacist of their choice. These decisions are causing consumers to sacrifice their traditional relationship with their family pharmacist—and the health protection and benefits it provides.²⁴

However, health plan sponsors who examine the evidence recognize that an investment in high-quality pharmacy services is health care money well spent. Just as drugs save money by preventing more expensive medical interventions, the services provided by neighborhood pharmacists are critical to high-quality care and cost containment.

Positive financial benefits result when pharmacists are intricately involved in patient care in institutional, clinic, and community pharmacy settings. A summary of recent research reports savings from decreased hospitalizations, lower drug costs, and prevention of adverse events with pharmacist care. In seven studies reviewed, for every \$1.00 spent to provide pharmacists' services, a mean of \$16.70 in benefits was obtained.²⁵

The benefits of pharmacist care were documented in The Kaiser Permanente/USC Patient Consultation Study. In general, pharmacist consultation with patients was associated with lower overall health care costs. In high risk patients cared for by pharmacists, the likelihood of a hospital admission was decreased, especially for emergency/urgent admissions. Pharmacist consultation for all new or changed prescriptions reduced office visit costs.

The community pharmacist's professional role in helping patients get the most from their prescribed drug therapy offers immediate cost savings. Drugs prescribed to prevent a heart attack are of no use if the patient is noncompliant and the plan ends up paying for the cost of surgery and hospitalization.

A modest investment in pharmacy services to ensure that the patient takes his or her medications properly becomes far more valuable than the cost of the medication itself. High-quality pharmaceuticals, combined with the pharmacist's professional services provides the most cost-effective health care treatment.²⁶

- Comparing the costs of drug therapy vs. other therapies in three common illnesses dramatizes the savings available through correct use of medications:²⁷

Illness	Cost
Heart Disease	
Drug Therapy	\$400 per year
Surgery and Hospitalization	\$15,000 per year
Ulcers	
Drug Therapy	\$1,000 per year
Surgery	\$25,000 per year
Gallstones	
Drug Therapy	\$2,000 per year
Surgery	\$12,000 per year

²⁴Family Pharmacist, undated news release, "NARD Launches Education Campaign Targeting Employers and Consumers."

²⁵Pharmacotherapy, November 6, 1996, "Economic Evaluations of Clinical Pharmacy Services—1988-1995."

²⁶Family Pharmacist, undated news release, "Third-Party Prescription Drug Programs and Pharmacy Services."

²⁷Family Pharmacist, undated news release, "Comprehensive Pharmacy Care."

The Overwhelming Evidence Confirming the Value of Pharmacist Care

*C*learly, pharmaceutical therapy is a major asset in the struggle to control health care costs. Medicines, when used properly, save money by shortening or eliminating the need for hospitalization. They also serve as substitutes for expensive surgery.

Dramatic evidence has shown major savings with some new medicines for diseases such as asthma, ulcers, gallstones, cancer, cardiovascular, kidney and infectious diseases, and mental disorders.

COSTS AND SAVINGS OF SOME IMPORTANT PHARMACEUTICAL THERAPIES²⁸

MEDICINE	CONDITION	COST	SAVINGS
Cromolyn	Asthma	\$0.90/day	\$1.64 billion/year
Ursodiol	Gallstones	\$6.00/day	\$2 billion/year
Beta blocker	Heart attack and glaucoma	\$1.00/day	\$4 billion/year
H2 antagonist	Ulcer	\$3.00/day	\$25,000/patient
Pentoxifylline	Intermittent claudication	\$1.00/day	\$250/patient
Muromonab-CD3	Kidney rejection	\$14.00/day	\$100,000/patient
Epoetin alfa	Anemia in kidney disease	\$11.00/day	\$6,500/patient
Clozapine	Schizophrenia	\$15.00/day*	\$58,000/patient
Cyclosporine	Immune suppression	\$16.00/day	\$174,000/patient
Filgrastim	Compromised immunity from cancer chemotherapy	\$1,300/treatment	\$7,000/patient
Sargramostim	Compromised immunity from bone marrow transplant	\$3,000/treatment	\$12,000/patient

* Includes blood testing and management

Quality pharmacist care is, by far, the best bargain in the health care industry today.

Although prescription medications and pharmacy services comprise less than 10 percent of health care costs, they often substantially reduce overall treatment costs.

²⁸Wellcome Trends in Pharmacy, January 1993, "What to Tell Patients About the Cost-Benefit of Medications."

DOCUMENTING THE VALUE OF PHARMACIST CARE /13

Time and again, researchers document the tremendous savings that pharmacist care can provide.²⁹

- † A Creighton University study found that every time a pharmacist intervened to educate a patient, prevent a drug-drug interaction, or ensure compliance with a prescription, he or she saved the payer an average of \$27.36.
- † In research at the University of Minnesota, changes in drug therapy recommended by pharmacists improved or resolved patients' illnesses in 80 percent of the cases and reduced the cost of medications per patient by \$49 to \$132 per clinic visit.
- † Lewin-VHI and the Center for Health Policy Studies both found independently that the federal government could have saved up to \$30 billion over five years by providing pharmacists with incentives to provide care to older adults.
- † A study at Purdue University found that pharmacy services saved the health care system an average of \$2.32 per prescription. The study indicated that pharmacy services saved the Medicaid budget \$784 million in 1993.
- † A study at the University of Arkansas demonstrated that \$6.13 was saved for every dollar spent on independent pharmacist care.
- † Researchers associated with the Canadian Pharmacists Association found that the average annual cost of medications for patients using medications as directed was \$250 per patient. For patients who stopped taking their medications, an average of \$1,000 per year was spent to treat their illness. An educational program for patients with high blood pressure improved correct medication usage, with estimated savings of \$94,000 in medication costs and \$114,000 in clinic visits.
- † In U.S. National Heart, Lung & Blood Institute research, a self-management program for children with asthma showed that for every dollar spent in patient education, \$100 was saved due to a significant reduction in hospital days.

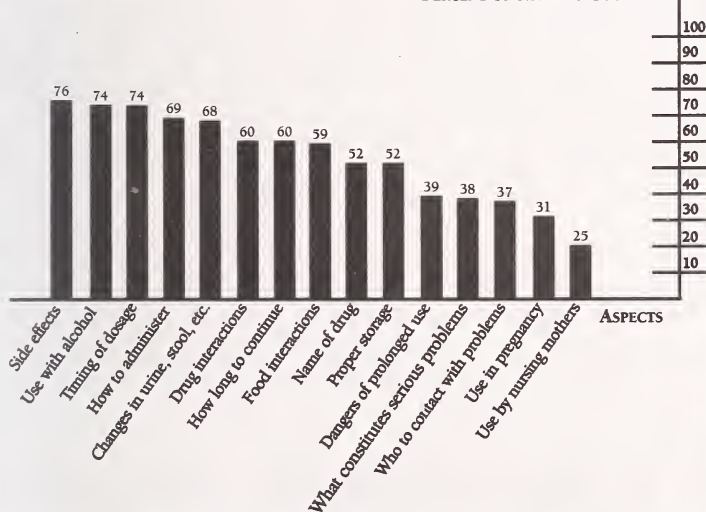
²⁹NARD Management Institute, undated news release, "Documenting the Value of Pharmacy Services."

The Community Pharmacist: On the Front Lines of Health Care Savings

A recent survey showed that during a typical 10-hour business day, independent pharmacists dispensed an average of 124 prescriptions, called physicians more than 13 times, received at least 10 calls from physicians, and spent nearly two hours counseling patients.³⁰

When counseling patients, pharmacists routinely provide information on the following aspects of medications as appropriate:³¹

PERCENT OF PATIENTS COUNSELED



In a recent survey, consumers indicated that the independent pharmacist is more likely than other pharmacists to relay prescription information verbally to patients. Of those consumers who patronized an independent pharmacy, 62 percent said they received prescription drug advice verbally from their pharmacist. By comparison, only 31 percent of chain drug store patients and 33 percent of those who went to supermarkets were counseled verbally.³²

Consumers feel most comfortable relying on their independent community pharmacists. According to Gallup polls, pharmacists have been America's most trusted professionals seven years running.³³

³⁰NARD Journal, Feb. 1988, "Patient Counseling in Independent Retail Pharmacy."

³¹Ibid.

³²NARD Management Institute, undated news release, "Documenting the Value of Pharmacy Services."

³³NACDS, undated article, "Studies Find Pharmacy Services Save the Health Care System Millions."

The Perfect Prescription For Managed Care Systems

*T*he managed care environment this country is heading toward can benefit greatly from pharmacist care because it emphasizes the need for the pharmacist to provide an enhanced role as a patient educator, focusing on total patient health and wellness, as well as disease management.

As managed care has grown, cost-containment pressures have increased. Americans can no longer afford to spend \$76 billion a year on problems caused by misuse of medications. The community pharmacist can make a difference. A recent study found that patients whose only counseling came from a pharmacist reported a 96 percent rate of correct medication usage. That compared with 89 percent for physician-only counseling, and 77 percent for no counseling.³⁴

Having pharmacist care in the basic package of a managed-care program will bring improved patient compliance, reduce inappropriate drug use and related hospitalization, and mean fewer preventable adverse drug effects and interactions.

Greater emphasis on pharmacist care can easily save billions of dollars in drug and other healthcare costs each year. And that means improved health and a better quality of living for all Americans.

**"Pharmacist care is the most critical quality
and cost control vehicle we have in the entire
health care system."**

**—Beach Hall, former Director of Health Benefits
at General Motors³⁵**

³⁴Donna S. West and Teresa H. Taylor, undated paper, "Documenting the Value of Pharmacy Services."

³⁵NARD, 1992, "Controlling Health Care Costs Through Comprehensive Pharmacy Care."



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